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Task Book

Advanced Course for Federal Agency Compensation Specialists

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U.S. Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program

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Task Book

Advanced Course for Federal Agency Compensation Specialists

U.S. Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program
1986

BEGIN WITH THIS BOOK

PREPARED BY:

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PAT QUICK

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CYNTHIA TAYLOR

DEBRA YOUNGBLOOD

Task Book
How to Take This Course

WHERE AND WHEN TO TAKE THIS COURSE:

This course is advanced job training for federal agency compensation specialists.

The course will take approximately 12 hours to complete and is designed to be taken on the job. It should be taken in a quiet place that will be free from interruptions.

This course is divided into segments consisting of seven modules. You should take these in the order presented and it is recommended that you complete a module in one session of study.

The modules are:

- o Claims Review, starting on page 1 of this book
- o Controversion, starting on page 25 of this book
- o Third Party, starting on page 92 of this book
- o Light Duty, starting on page 115 of this book
- o Review of the Chargeback List, starting on page 172 of this book
- o Long Term Case Review, starting on page 193 of this book
- o Rehabilitation, starting on page 257 of this book

MATERIALS NEEDED:

- o Task Book
- o Resource Book

TAKING THE COURSE:

Sequences in the materials will be organized as follows:

- o This book contains the directions. It will refer you to the Resource Book and ask you to read some information or rules.
- o Next it will ask you to solve a problem or make a decision on the basis of the rules in the Resource Book. You will record your answers in this book (the Task Book).
- o Then you will compare your answers to the answer sheet in the Task Book.
- o If there are any major differences between your answers and the answer sheet, you will be instructed to re-read the section in the Resource Book.
- o After you have cleared up any differences in the answers, then you will begin a new sequence in the Task Book.

GO ON TO THE NEXT PAGE TO BEGIN THE COURSE.

Reading

A prerequisite to filling the role of the compensation specialist is to establish a claims processing system in your installation that will permit you to get the information you need quickly to do your job effectively. Your first reading will describe that system. The rest of the course will give you practice in reviewing claims and long term cases.

Now, turn to the Resource Book and read pages i through 7. When you have finished the reading, return to this book and go to page 1.

Module I Claims Review

In this module on Claims Review we will revie some typical claims that have been submitted to the compensation office. You will be asked to make a number of decisions about the claims.

In reviewing these cases, you will begin the process of recognizing the INDICATOR, making your QUERY, EVALUATING the response and coming up with a RESOLUTION for the situation.

GO TO PAGE 2.

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 1

Read pages 8 - 10 and 14 - 16 in the Resource Book on examining the claim form and reviewing the medical report. When you have completed the reading, return to this page and follow the instructions below.

TASK:

Review the following CA-1 (Notice of Injury) and medical report for John A. Smith on pages 3 - 5. Look for any unresolved issues. Then turn to the worksheet on page 6 to answer the questions.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
Smith, John A.	2-24-24		555-12-1212

5. Employee's Home Mailing Address (No., street, city, state, zip code)
P.O. Box 112
Scottsboro, Alabama 35807

6. Home Telephone
Area Code: 205
Number: 555-2101

7. Name and Address of Employing Agency
Tennessee Valley Authority
Bellefonte Nuclear Plant
Hollywood, Alabama 35803

8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Reactor Building

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
9:00 ☒ AM ☐ PM Feb. 1, 1994	Feb. 2, 1994	Wife/Husband ☒ Children Under 18 Years Old ☐	Electrician

13. Cause of Injury (Describe how and why the injury occurred)
I picked up a drill (10 lbs.) to hand it to another Electrician and I got a catch in my back.

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Strain low back

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

John A. Smith
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)
Yesterday, John handed me a drill and then grabbed his back and said it was hurting.

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Ralph A. Longley	Box 75, Winding Lane Huntsville, Alabama 35805	2/2/84

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
Tennessee Valley Authority	OEDC - Construction

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Lois P. Ulrickson, 124 Edney Bldg., Chattanooga, TN 37401

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 7:30 ☒ AM ☐ PM Ends 4:00 ☐ AM ☒ PM	8	S (M T W T F) S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
9:00 ☒ AM ☐ PM Feb. 1, 1984	Feb. 2, 1984	2:00 pm Feb. 2, 1984	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor at Time of Injury
Feb. 2, 1984	$ 13.00 per hour	☐ AM ☐ PM	James Walden

35. Was Employee in Performance of Duty At The Time of Injury? ☒ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee is Disabled For Work?
Feb. 2, 1984	Dr. Paul Perkins 1000 McCallie Avenue Chattanooga, TN 37401	☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☒ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☐ Medical Expense Incurred or Expected. Forward this Form to OWCP
☒ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor	46. Title and Office Phone Number	47. Date *(mo., day, year)*
James O Walden	Const. Supt.	2/8/84

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE: SMITH, JOHN A.
2. EMPLOYEE'S ADDRESS: P.O. Box 112, Scottsboro, Alabama 35768
3. DATE AND HOUR OF INJURY: Feb 1, 1984
4. PERIOD OF INCAPACITATION FOR WHICH CLAIMED AS A RESULT OF PAY LOSS: FROM 2-2-84 continuing
5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE? Employee states he strained his back lifting drill weighing approx 100 lbs at work.
6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)? X-rays reveal severe degenerative disc disease no change since 11/83 x-rays
7. WHAT IS YOUR DIAGNOSIS? SAME AS #6
8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts) ___ YES ___ NO

DID INJURY REQUIRE HOSPITALIZATION? X YES ___ NO
IF YES, DATE OF ADMISSION (Mo., Day, Year) 2/2/84
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? X YES ___ NO
11. OPERATIONS (If any, describe type): CONTINUE TO RECOMMEND SPINAL FUSION
12. DATE OPERATIONS PERFORMED (Mo., Day, Year)
13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? MEDICATIONS, MYELOGRAM
14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? UKNOWN AT THIS POINT
15. DATE OF FIRST EXAMINATION (Mo., Day, Year): 840202
16. DATES OF TREATMENT (Mo., Day, Year): 1982 and continuing
17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year): N/A
18. PERIOD OF DISABILITY (If termination date unknown, so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 2/3/84 TO CONTINUING
PARTIAL DISABILITY: FROM ___ TO ___
19. DATE EMPLOYEE ABLE TO RESUME LIGHT WORK / REGULAR WORK: n/t
20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK. ___ YES X NO IF YES FURNISH DATE ADVISED.
21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS: N/A
22. GENERAL REMARKS AND RECOMMENDATIONS FOR FURTHER CARE, IF INDICATED: MYELOGRAM CONFIRMS MY RECOMMENDATION OF NEED FOR SPINAL FUSION. PATIENT REMAINS IN HOSPITAL
23. SIGNATURE OF PHYSICIAN: Paul Perkins MD
24. ADDRESS (Number, street, city, State, ZIP Code): 1000 McCallie Avenue, Chattanooga, TN
25. DATE OF REPORT (Mo., Day, Year): 2/3/84

CA-20
(REV. AUG. 1978)

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 1

Which of the following descriptions most closely describes the major issue in the case? Pick your answer and turn to the page and box indicated.

a. Description of the injury submitted by the claimant is too incomplete. Turn to page 22, Box 2.

b. There are no work limitations specified. Turn to page 23, Box 1.

c. There is a lack of evidence of job-relatedness. Turn to page 33, Box 4.

d. The type of injury claimed on the CA-1 is probably an occupational disease. Turn to Page 30, Box 1.

TASK BOOK
CLAIMS REVIEW
SMITH CASE
TASK 2

Should you wish to refer to the Resource Book, consult pages 14 and 15.

Which of the questions for the doctor listed below would provide the information most necessary for resolving the question of causality?

Select your answer and turn to the page indicated.

a. Are the findings of severe degenerative disc disease causally related to the work injury reported? Turn to page 23, Box 4.

b. When will the claimant be able to return to limited duty? Turn to page 33, Box 1.

c. Is the total disability a result of the work injury reported? Turn to page 22, Box 1.

d. To what extent did the injury claimed contribute to the claimant's current disability? Turn to page 30, Box 3.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

Review the following CA-1 and medical disability certificates submitted by George R. Thomas and answer the questions on page 13.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee *(Last, first, middle)*	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
George R Thomas	3-12-29	☑ Male ☐ Female	006-15-1182

5. Employee's Home Mailing Address *(No., street, city, state, zip code)*
1106 Main St
Towson, Maryland 21204

6. Home Telephone
Area Code: 301
Number: 667-4502

7. Name and Address of Employing Agency
U.S.P.S
900 E. Fayette St
Balto, MD 21233-9408

8. Place Where Injury Occurred *(e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)*
2nd workfloor - M.P.O
Operation 030

9. Date and Hour of Injury *(mo., day, year)*	10. Date of This Notice *(mo., day, year)*	11. Dependents	12. Employee's Occupation
6/25/83 5:30 ☐ AM ☑ PM	7/15/83	Wife/Husband ☑ Children Under 18 Years Old ☑	Mail handler

13. Cause of Injury *(Describe how and why the injury occurred)*
Unloading a belt from a truck, I fractured my left little toe when the belt slipped and ran over my foot

14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*
fractured left little toe

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.
I did not think injury was serious.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

George R. Thomas
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*
N/A

18. Witness' Signature	19. Witness' Address	20. Date Signed *(mo., day, year)*

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
U.S.PS	Balto MD 21233 #357000

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
711 E Fayette St - Rm 217 · 728-4977
Balto MD 21233

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 3:30 ☐ AM ☑ PM Ends 12:00 ☐ AM ☑ PM	8	(S) M T (W) (T) (F) (S)

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
6/25/83 5:30 ☐ AM ☑ PM	7/9/83	7/7/83 12:00 PM	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor at Time of Injury
7/8/83	$ 22.060 per yr	7/18/83 3:30 ☐ AM ☑ PM	R Most

35. Was Employee in Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?

☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee is Disabled For Work?
7/9/83	Johns Hopkins Hospital 600 S Broadway Balto Md 21205	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☑ No. If No, Furnish A Detailed Explanation.

Mr. Thomas was not assigned to unload Delta on 6/25/83

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions

☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☑ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor	46. Title and Office Phone Number	47. Date *(mo., day, year)*
R. Most	Supvr. Mails	7/16/83

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

DISABILITY CERTIFICATE:

JOHNS HOPKINS HOSPITAL
600 S. Broadway
Baltimore, MD 21205

7/8/83

George R. Thomas was seen in our Emergency Room on 7/8/83 and is unable to work through 7/9/83 due to a fracture of his left little toe. Patient states the injury happened at work on 6/25/83.

E. L. Wright, M. D.

Patient Instructions:
Tape toes for comfort. Take aspirin as needed.
Elevate the foot for 24 hours.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

DISABILITY CERTIFICATE:

JOHNS HOPKINS HOSPITAL
600 S. Broadway
Baltimore, MD 21205

7/10/83

George R. Thomas was seen in our Emergency Room on 7/10/83 and is unable to work through 7/14/83 as a result of a fractured left toe. Patient states the injury occurred at work on 6/25/83.

R. A. Johnson, M. D.

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 1

Is George Thomas's claim ready to be sent to OWCP?

a. Yes ____ Turn to page 30, Box 2

b. No ____ Turn to page 22, Box 3

TASK BOOK
CLAIMS REVIEW
THOMAS CASE
TASK 2

Pick the one statement below which representa a major issue or issues that need to be resolved in George Thomas's case before it can be sent to OWCP. Then turn to the page indicated next to your choice.

a. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. Turn to page 22, Box 4.

b. There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed. Turn to page 33, Box 3.

c. The Doctor's report raises questions about whether the injury occurred at work. Turn to page 31, Box 2.

d. There were no witnesses to the injury. Turn to page 30, Box 4.

e. Both a and b above. Turn to page 23, Box 2.

f. Both a and c. Turn to page 24, Box 3.

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 1

Read pages 11 - 13 in the Resource Book. Then review the following CA-1 and medical report on pages 16 - 18 for the claim of Thomas F. Merritt.

Look for any indicators of problems in the case. Then answer the questions on page 19.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
Merritt, Thomas F.	9/29/48		100-56-6726

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
405 Columbia ST Portsmouth, Va	Area Code: 804 Number: 393-8181

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Norfolk Naval Shipyard Industrial Relations Office Portsmouth Va	Bldg 171

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
10:30 ☒ AM ☐ PM 11/22/83	11/23/83	Wife/Husband ☐ Children Under 18 Years Old ☐	Laborer

13. Cause of Injury *(Describe how and why the injury occurred)*

I was movin office furniture when I lifted a chair and felt a sharp pain in my wrist.

14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*

Right wrist

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Thomas F. Merritt
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
Navy

22. Bureau or Office
Norfolk Naval Shipyard

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, Va. 23709

24. Regular Work Day
Begins 7:20 ☑ AM ☐ PM
Ends 4:00 ☐ AM ☑ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*
11/22/83 ☑ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
11/23/83

29. Date and Hour Stopped Work *(mo., day, year)*
N/A

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*

31. 45 Day Period Begins *(mo., day, year)*
No time lost yet

32. Pay Rate When Employee Stopped Work
$ ____ per ____

33. Date and Hour Employee Returned to Work *(mo., day, year)*
N/A ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury
Mr. Wilson

35. Was Employee In Performance of Duty At The Time of Injury? ☐ Yes, ☑ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.
job orders do not show employees work assignment as moving furniture on 11/22/83.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
11/22/83

39. Name and Address of Physician First Providing Medical Care
Shipyard Dispensary
Dr. Gerald Mc Adams
1011 London Blvd.
Norfolk, Va

40. Do Medical Reports Show Employee Is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☑ No. If No, Furnish A Detailed Explanation.
employee's work assignment was not moving furniture.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Walter Wilson

44. Title and Office Phone Number
Foreman 533-8162

45. Date *(mo., day, year)*
11/23/83

SHIPYARD DISPENSARY

Medical Entry

11/22/83 Patient complaining of pain in right leg on movement. Patient stated he slipped on wet surface and has since had pain in right leg.

Examination revealed full range of motion of right leg with a straight leg raising of 60°. X-rays were negative for fracture.

Treatment: Medication for pain and work restrictions for light duty assignment. Return to clinic in two weeks for re-evaluation.

s/ W A Moark

W. A. Moark, M. D.

12/5/83 Patient in for re-evaluation for right leg. Examination reveals full range of motion and no edema. Will return patient to full duty. However, he requests to be referred to his private medical doctor. Will grant this request and patient was instructed to contact compensation office.

s/ W A Moark

W. A. Moark, M. D.

Enclosure 2

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 1

From the problems listed below, identify the one answer that applies in this case. Select your answer below and turn to the page indicated to check your answer.

a. Both b and c are problems. Turn to page 24, Box 2.

b. There is a conflict between the supervisor's statement of work assignment and the claimant's description of injury. Turn to page 33, Box 2.

c. There is a conflict between the Ship Dispensary medical report and the claimant's description of the part of the body injured. Turn to page 31, Box 1.

d. There are no witnesses to the injury claimed. Turn to page 41, Box 2.

To resolve the conflict between the supervisor's statement of work assignment and the claimant's description of injury, which of the following sources is most important?

a. Interview the claimant. Turn to page 24, Box 1

b. Interview the supervisor. Turn to page 23, Box 3

c. Look for witnesses. Turn to page 170, Box 2

d. Get a more detailed medical report from the Dispensary. Turn to page 34, Box 4

TASK BOOK
CLAIMS REVIEW
MERRITT CASE
TASK 3

To resolve the conflict between the Ship Dispensary medical report and the claimant's description of the part of the body injured which of the following would you do? After you select your answer, turn to the page indicated.

a. Interview the claimant. Turn to page 41, Box 3

b. Interview the supervisor. Turn to page 24, Box 4

c. Look for witnesses. Turn to page 34, Box 1

d. Get a more detailed medical report from the dispensary. Turn to page 31, Box 3

From page 7

1

Question "c" does not ask for a description of how much the work injury contributed to the disability.

Return to page 11 and try again.

From page 6

2

Choice "a" is not the major issue. Since the degenerative disc disease is an ample explanation for his total disability, we do not need a better description of the accident to explain how it could result in such a severe condition.

Return to page 6 and make another selection.

From page 13

3

Correct. The case is not ready to be submitted to OWCP.

Turn to page 14 for the next task.

From page 14

4

True. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. However, there is one other issue that should be resolved at this time.

Return to page 14 and try again.

From page 6

1

Choice b. is not really an issue at this point. The fact that the work limitations are not specified is not an issue since the claimant is hospitalized. It would only become an issue after establishing a causal relationship between picking up the drill and the claimant's disability.

Return to page 6, review the case and select another answer.

From page 14

2

Correct. Both of these are issues.

(a.) There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place.

and

(b.) There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed.

Turn to page 15 for the next task.

From page 20

3

This is not really necessary. The supervisor is already on record as stating that the employee was not assigned to movie furniture, even though he has not come forth with other evidence.

Return to page 20 and make another choice.

From page 7

4

Question a. "are the findings of severe degenerative disc disease causally related to the work injury reported?" is not the best question. We already know that severe degenerative disc disease preceded the work injury and therefore is not a result of it.

Return to page 7 and try again.

From page 20

1

Correct. It is important to give the claimant the opportunity to explain why he was moving furniture when that was not his assignment. Find out if he was working with anyone. Were there any witnesses?

Now turn to page 21 for the next task.

From page 19

2

Correct. Both b and c are problems.

Turn to page 20 for the next task.

From page 14

3

You are partly right. There is a conflict between the employee's statement and the supervisor's statement that the claimant was not working in the area where the injury took place. However item c "The Doctor's report raises questions about whether the injury occurred at work" is not a major issue. It is true that the report does not provide a complete history of injury. This is just one of the weaknesses of the medical evidence. Return to page 14 and make another selection.

From page 21

4

No. The supervisor has no direct information on how the injury happened or what part of the body was affected. Return to page 21 and make another choice.

MODULE 2

CONTROVERSION

As in the previous module, you will be given a case and a series of tasks. For each case you will be asked to:

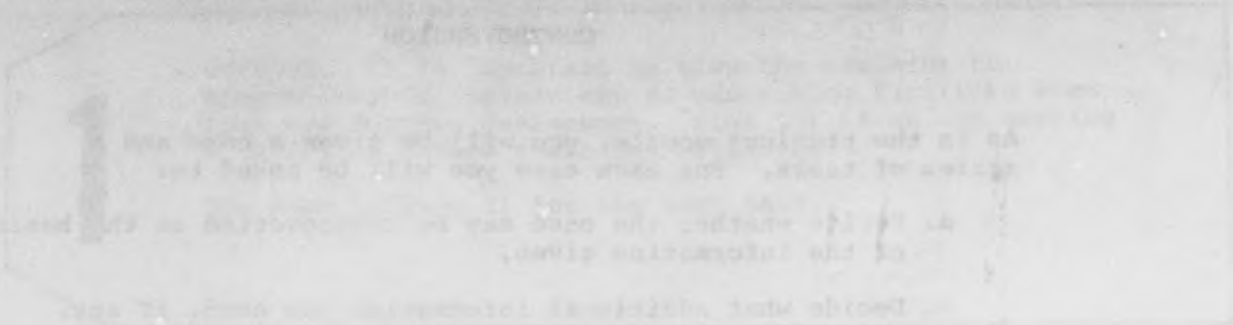
a. Decide whether the case may be controverted on the basis of the information given,

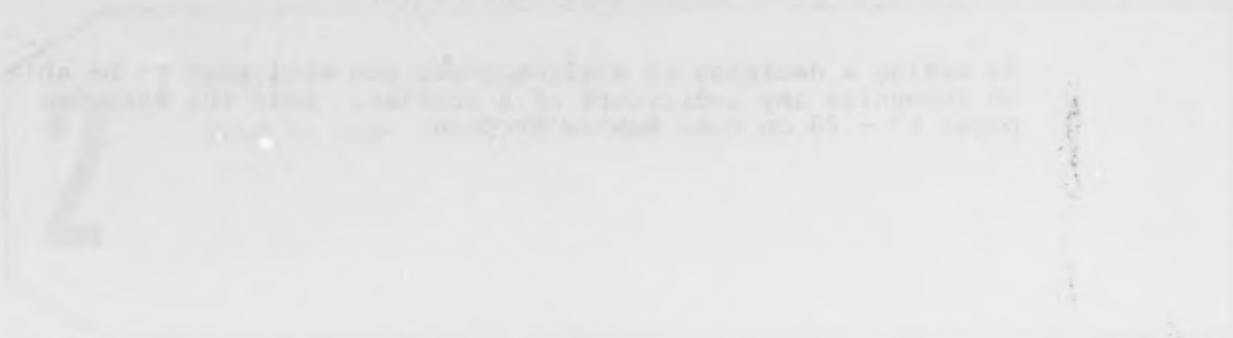
b. Decide what additional information you need, if any,

c. Evaluate any additional information, and decide whether the claim should be controverted.

In making a decision on a given case, you will need to be able to recognize any indicators of a problem. Read the Resource pages 17 - 20 on Case Review Process.

TURN TO PAGE 26 TO BEGIN THE FIRST CASE.





TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 1

Before beginning this case, read the Resource Book on Controversion, pages 26 and 27 up to Number 2.

Review the attached CA-1 completed by John E. Smithers and received for processing in the compensation office on April 2, 1984. Then turn to page 29 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. Male / Female	4. Social Security Number
Smithers John E	11-01-50	☑ Male ☐ Female	123-58-3070

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
902 East Fayette Street Baltimore, Maryland 21233	Area Code: 301 Number: 436-8051

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
US Postal Service 900 West Pratt Street Baltimore, Maryland 21202-9208	1208 Walker Avenue

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
2/20/84 12:30 ☐ AM ☒ PM	2/20/84	Wife/Husband ☑ Children Under 18 Years Old ☐	Letter Carrier

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
While delivering a package, dog ran out opened door and bit my leg	right leg

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

I gave it to my supervisor and he lost it.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

John E. Smithers
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

None

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
US Postal Service

22. Bureau or Office
Baltimore, Md 21202-9208

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
900 West Pratt Street
Baltimore MD. 21202-9208

24. Regular Work Day
Begins 6 00 ☒ AM ☐ PM Ends 2 30 ☐ AM ☒ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) F (S)

27. Date and Hour of Injury *(mo., day, year)*
2/20/84 12 30 ☐ AM ☒ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
2/20/84 (Verbal)

29. Date and Hour Stopped Work *(mo., day, year)*
2/20/84 12 30

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
N/A

31. 45 Day Period Begins *(mo., day, year)*
2/21/84

32. Pay Rate When Employee Stopped Work
$22,402 per yr

33. Date and Hour Employee Returned to Work *(mo., day, year)*
2/22/84 6:00 ☒ AM ☐ PM

34. Name of Supervisor at Time of Injury
Ray Jones

35. Was Employee in Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☑ Yes ☐ No. If Yes, Furnish Name and Address of Party Responsible.
Homeowner
1208 Walker Avenue
Baltimore MD 21202

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*
2/20/84

39. Name and Address of Physician First Providing Medical Care
Johns Hopkins Hospital
600 Broadway
Baltimore MD. 21205

40. Do Medical Reports Show Employee is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☑ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor
Ray Jones

46. Title and Office Phone Number
Supvr Delivery 922-4908

47. Date *(mo., day, year)*
4/2/84

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 1

Select the letter next to the statement below that best describes the issue involved and turn to the page indicated to check your answer.

a. There is no issue. The claim is ready to be submitted to OWCP. Turn to page 41 Box 1.

b. The issue is that this claim should be an occupational disease claim. Turn to page 31 Box 4.

c. The issue is that the injury was not reported on an approved form within 30 days after the injury. Turn to page 34 Box 3.

d. The issue is that the injury occurred off the employing agency's premises and the employee was not in performance of duty. Turn to page 42 Box 2.

From page 6

1

Choice "d" - that the injury claimed is an occupational disease is possible. But, there is no evidence that the degenerative disc disease is work-related, nor is the claimant asserting this.

Return to page 6 and make another choice.

From page 13

2

You said yes. You are not quite correct. There are at least two "issues" that should be resolved first. First, review page 9 and pages 14 and 15 of the Resource Book. Then return to page 13 and answer the question again.

From page 7

3

Correct. Question d. "To what extent did the reported injury contribute to the claimant's current disability?" is the best answer. The disability may be entirely due to the pre-existing condition and hence not compensable. However, any part of the current disability which has resulted from the reported injury is compensable.

Go to page 8 to do another case.

From page 14

4

Choice d "There were no witnesses to the injury" is not a good choice. The claimant states that there were no witnesses to the injury. There, in fact, does <u>not</u> have to be a witness to make a claim valid. Return to page 14 and select another answer.

From page 19

1

This is correct. There is a conflict between the ship dispensary medical report and the claimant's description of the part of the body injured.

Now return to page 19 and review the choices. Are you sure there are no others?

From page 14

2

Item c "The Doctor's report raises questions about whether the injury occurred at work" is not a major issue. It is true that the report does not provide a complete history of injury. This is just one of the weaknesses of the medical evidence. Answer "b" gets more to the point of the larger issue of lack of medical evidence.

Return to page 14 for another try.

From page 21

3

The dispensary as a source would not be helpful at this point. We first need a clearer description of how the injury occurred and how the different parts of the body were affected.

Return to page 21 for another attempt.

From page 29

4

No. The dog bite on the leg is a traumatic injury, not an occupational disease.

Return to page 29 and select another answer.

At this point, which step must you take? Select one of the choices below, then turn to the page indicated to check your answer.

a. Contact the claimant's supervisor to see if there were any witnesses who saw the claimant give the form to the supervisor. Turn to page 34, Box 2.

b. Contact the claimant's supervisor to verify the date the claim form was first submitted by the claimant to the supervisor. Turn to page 41, Box 4.

c. Contact the claimant to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. Turn to page 43, Box 2.

d. Both a and c above. Turn to page 44, Box 1.

e. Both b and c above. Turn to page 42, Box 3.

From page 7

1

The question asked in b. "when will the claimant be able to return to limited duty?" may turn out to be important, but the more basic issue is still establishment of causality.

Return to page 7 and select another answer.

From page 19

2

This is correct. There is a conflict between supervisor's statement of work assignment and claimant's description of injury.

Return to page 19. Are you sure there are no other problems?

From page 14

3

Very good. There is inadequate medical evidence to justify total temporary disability resulting from the injury claimed. However, there is another issue that should be resolved now.

Return to page 14 to make another selection.

From page 6

4

The correct answer is "c" - lack of evidence of job relatedness. The major issue is the cause of the condition of the person's back. The doctor's medical report clearly states that the claimant had severe degenerative disc disease several months prior to the injury reported. It also states that the current condition is the same as it was then.

Turn to page 7 to begin the next task.

From page 21

1

This is not the best choice. There may be witnesses who could supply useful information, but there is a far more direct route. Return to page 21 for another selection.

From page 32

2

Contacting "the claimant's supervisor to see if there were any witnesses who saw the claimant give the form to the supervisor" is not a necessary step. If the supervisor does not remember that the claimant gave him the form, he certainly will not remember any witnesses.

Return to page 32 and make another choice.

From page 29

3

Correct. The best answer is "3" - that the injury was not reported on an approved form within 30 days after the injury. The date of injury was 2/20/84, but the claim was not received in the compensation office until April 2, 1984, after the 30 day filing limit.

Turn to page 32 to continue.

From page 20

4

No. Medical information, even if complete, would not settle the problem of where the claimant was when he sustained his injury.

Return to page 20 and try again.

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

Read pages 32 - 34 in the Resource Book in the section on Controversion. You might also want to review pages 26 - 27 in the Resource.

The claimant's supervisor has advised you that he has no record of the employee ever completing Form CA-1 until April 2, 1984. He has given you the written statement on the following page. You have also requested and obtained a written statement from the claimant.

Read these two statements on the two following pages and answer the questions on pages 38 - 40.

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

STATEMENT

April 3, 1984

TO: Mary Denton
Injury Compensation Specialist

This is in response to your telephone call requesting information on a claim submitted by John E. Smithers. Mr. Smithers requested a CA-1 form from me yesterday and gave it back to me to sign on the same day April 2, 1984. This is the only time this employee requested a claim form for the dog bite he told me he received back in February.

s/ Ray Jones

Ray Jones
Supervisor, Delivery

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

STATEMENT

April 3, 1984

TO: Mary Denton
Injury Compensation Specialist

I submitted a CA-1 to my supervisor on 2/20 when I left at 12:30 p.m. The supervisor did not give me a receipt for the CA-1. I did not know I was supposed to get one.

s/ John E Smithers

John E. Smithers

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 3

You have decided to controvert the claim.

Select the statement below that best describes your basis for controverting this claim. After choosing your answer, turn to the page indicated to check your answer.

a. **The injury was not reported on an approved form within 30 days of the injury. Turn to page 44, Box 4.**

b. **The injury occurred off the employing agency's premises and the employee was not involved in official "off premises" duties. Turn to page 42, Box 1.**

c. **The injury was caused by the employee's willful misconduct. Turn to page 50, Box 3.**

d. **Causal relationship has not been established. Turn to page 43, Box 3.**

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 4

Indicate whether or not you would terminate COP and your rationale for that decision by selecting the best answer from the choices below. Then turn to the page indicated.

a. You would not terminate COP because the employee went to the hospital and there are probably medical bills that have to be paid. Turn to page 43, Box 1.

b. You would terminate COP because the injury did not occur during the performance of duty. Turn to page 44, Box 3.

c. You would terminate COP because a claim not being timely filed is one of the reasons you can legally terminate COP. Turn to page 50, Box 1.

d. You will terminate COP because there is no medical evidence that the injury ever occurred. Turn to page 42, Box 4.

TASK BOOK
CONTROVERSION
SMITHERS CASE
TASK 5

Circle the letter of the item below you would not enclose as documentation in your controversion package to OWCP for this case. Then turn to the page given at the end of your selection to check your answer.

a. The claimant's written statement. Turn to page 43, Box 4.

b. The supervisor's written statement. Turn to page 50, Box 2.

c. The CA-1 form. Turn to page 44, Box 2.

d. A medical report. Turn to page 63, Box 4.

From page 29

1

Not correct. There is a basic issue in this case. Return to page 29 for another try.

From page 19

2

Not really. Although there may be witnesses, the best source of finding them would be through the claimant.

Return to page 19 and make another selection.

From page 21

3

Correct. For the conflict in medical information, again the employee would be the best source. The conflict between the employee's statement and the dispensary report is obvious. If the claimant is asked to describe in detail exactly how the injury occurred, he may have a rationale that connects the wrist and leg injuries. Further, we do not know at this point whether he has used, or is using other medical facilities, such as a private physician, to treat the injured wrist. Turn to page 25 to begin the next module.

From page 32

4

Correct. It is important to contact the claimant's supervisor (choice "b") to verify the date the claim form was first submitted by the claimant to the supervisor. If the supervisor remembers the claimant giving the CA-1 to him within the 30 day time period and the supervisor did, in fact, lose it, then the claimant has fulfilled his responsibility. But there is also one other step you must take.

Return to page 32 and select the other necessary step.

From page 38

1

This is not true. The employee was involved in official duties, even though off premises.

Return to page 38 to make another selection.

From page 29

2

It is true that the injury occurred off the agency's premises, but since it was in the performance of duty (delivering mail) it is clearly covered.

Return to page 29 and select another answer.

From page 32

3

Correct. Both b and c are necessary. It is important to contact the claimant's supervisor ("b") to verify the date the claim form was first submitted to the supervisor. If the supervisor remembers the claimant gave the CA-1 to him within the 30 day time period and the supervisor did, in fact, lose it, then the claimant has fulfilled his responsibility. But there is also another step you must take. You must contact the claimant ("c") to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce it, this will substantiate his claim and he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. Now go to page 35.

From page 39

4

You have not reached the point of considering medical evidence yet, so choice "d." - "no medical evidence that the injury ever occurred" is not correct.

Return to page 39 and make another selection.

From page 39

1

No. This provides no legal basis for controverting COP.

Return to page 39 and make another choice.

From page 32

2

You want to contact the claimant (choice "c") to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce the receipt this will substantiate his claim and he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. However, there is one other thing you should do.

Return to page 32, examine the case and select another alternative.

From page 38

3

No. Establishment of causal relationship is not an issue in this case.

Return to page 38 for another selection.

From page 40

4

No. In this case the claimant's written statement is a necessary part of the claim, since it is the claimant's explanation of the lack of timeliness.

Return to page 40 and select another answer.

From page 32

1

Choice "c" is correct. You want to contact the claimant to ask him to produce his receipt for the CA-1 that he says he submitted to his supervisor. If he can produce the receipt he will have fulfilled his responsibility, even if the supervisor subsequently lost the original form. There is one other thing you should do. However, choice a, contacting the claimant's supervisor is not a necessary step. If the supervisor does not remember that the claimant gave him the form, he certainly will not remember any witnesses. Return to page 32 and make another selection.

From page 40

2

No. The CA-1 form is always required. It is the official claim form.

Return to page 40 and make another selection.

From page 39

3

Not so. The injury did occur during the performance of duty - delivering mail.

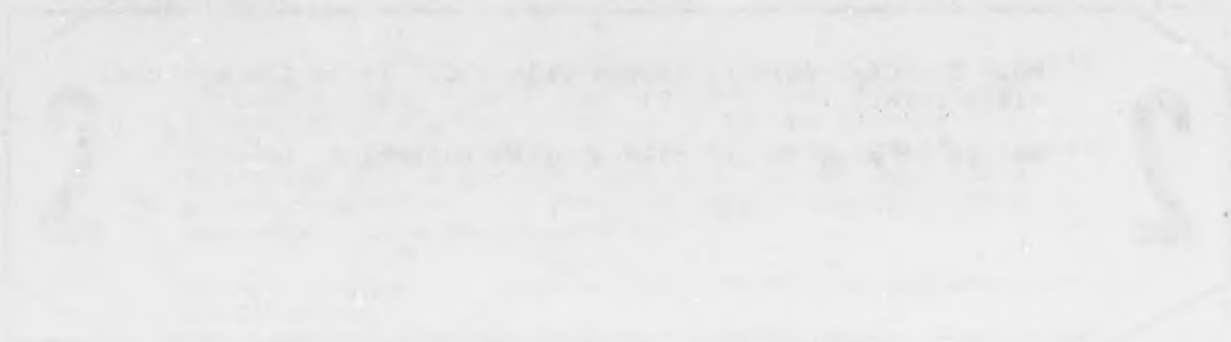
Return to page 39 and try again.

From page 38

4

Correct. The basis for controverting this claim is the injury was not reported on an approved form within 30 days of the injury.

Now turn to page 39 for the next task.



TASK BOOK
CONTROVERSION
MURPHY CASE

First, read pages 21 - 25 in the Resource Book.

Then review the CA-1 and medical report which follow on pages 46 - 48 to determine if this case should be controverted and answer the questions on page 49.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
Murphy, Samuel	1-10-50		330-46-1130

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: 312 Number: 881-7110
8510 So. Wabash apt 3C	

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Chicago Bulk Mail 1500 W. Roosevelt Rd Chicago Ill 60607	1st floor hallway

9. Date and Hour of Injury (mo., day, year) ☐ AM ☐ PM	10. Date of This Notice (mo., day, year)	11. Dependents Wife/Husband ☐ Children Under 18 Years Old ☐	12. Employee's Occupation
1-25-84	1-25-84		Mail

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Ernest Jones hit me in the mouth with his fist	split my lip and knocked 2 teeth loose

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Samuel Murphy
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
U.S. Postal Service

22. Bureau or Office

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Chicago Bulk Mail Ctr 7500 W. Roosevelt Rd Forest Park IL 60609

24. Regular Work Day
Begins 7:00 ☑ AM ☐ PM Ends 3:30 ☐ AM ☑ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S M (T) (W) (T) (F) (S)

27. Date and Hour of Injury *(mo., day, year)*
1-25-84 ☐ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
1-25-84

29. Date and Hour Stopped Work *(mo., day, year)*
N/A

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*

31. 45 Day Period Begins *(mo., day, year)*
N/A

32. Pay Rate When Employee Stopped Work
$ 9.79 per hrly

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury
Eileen Taylor

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☑ Yes ☐ No. If Yes, Furnish Detailed Report. Clrk and employee Jones got into a fist fight after a hand truck

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
1/25/84

39. Name and Address of Physician First Providing Medical Care
Loyola Hospital

40. Do Medical Reports Show Employee Is Disabled For Work?
☐ Yes ☑ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Eileen Taylor

44. Title and Office Phone Number
Supv. of Mails

45. Date *(mo., day, year)*
1/26/84

LOYOLA HOSPITAL
Emergency Room Report

This 34 year old male was treated for laceration of the mouth on 1/25/84. X-rays of the teeth revealed a loosening and displacement of the 2 top incisors on the left. Patient was seen by the orthodontist, who administered sodium and salt solution for rinse over gums. Patient is to continue using sodium and salt water until loosening of the incisors resolves.

TURN TO THE NEXT PAGE.

TASK BOOK
CONTROVERSION
MURPHY CASE

Which of the following statements describes the appropriate course of action. After selecting your answer, turn to the page indicated next to the answer.

a. Do not controvert the case because the fight was due to a matter relating to work. Turn to page 79, Box 1.

b. Interview both parties involved in the fight to clearly establish that the fight was really over a work matter. Turn to page 63, Box 3.

c. Do not controvert the case since there was no time loss. Turn to page 50, Box 4.

d. Controvert the case because the medical report does not establish the job relatedness of the injury. Turn to page 80, Box 2.

From page 39

1

You are correct. You would terminate COP because a claim filed later than 30 days after injury is not timely filed and is one of the reasons you can legally terminate COP.

Turn to page 40 for the next task.

From page 40

2

No. The supervisor's written statement is an essential part of the evidence for controversion.

Return to page 40 and try again.

From page 38

3

This is not true. There is no evidence that the injury was caused by the employee's willful misconduct.

Return to page 38 and select a different answer.

From page 49

4

No. The fact that there is no time loss is not relevant. There are medical costs involved.

Return to page 49 and make another selection.

TASK BOOK
CONTROVERSION
JONES CASE

First read pages 27 (paragraph 2.) - 31 in the Resource Book.

Then review the case material for Brandon E. Jones on pages 52 - 56.

Then turn to page 57 to answer the questions.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
Jones, Brandon E.	6/15/46		318-42-0892

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: Number:
313 Bayberry Lane Chesapeake, Virginia 23709	804 488-1240

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Norfolk Naval Shipyard Industrial Relations Office Portsmouth, Va 23709	USS JFK

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents ☐ Wife/Husband ☐ Children Under 18 Years Old	12. Employee's Occupation
7/8/83 ☒ AM ☐ PM	7/8/83		Pipefitter

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
I was laying 18" piping when I bent down to get my wrench and hit my elbow on the pipe.	Right Elbow

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Brandon E. Jones
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
NAVY	Norfolk Naval Shipyard

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, VA 23709

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 7:20 ☑ AM ☐ PM Ends 4:00 ☐ AM ☑ PM	8	S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
7/8/83 7:30 ☑ AM ☐ PM	7/8/83	7/9/83	

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor At Time of Injury
7/9/83	$ —— per ——	Still Out ☐ AM ☐ PM	Mr. Barnes

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee Is Disabled For Work?
7/9/83	Dr. William Harris 210 Washington Ave Norfolk, VA 23710	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor	44. Title and Office Phone Number	45. Date *(mo., day, year)*
C Barnes	Foreman 396-4271	7/8/83

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr. William Harris
210 Washington Ave
Norfolk, VA 23710

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Jones, Brandon E.	7/8/83	Pipefitter

5. DESCRIPTION OF INJURY OR DISEASE

Was laying 18" piping when right elbow struck the pipe

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Susan M. Peters	Head, Employee Services Div.
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
(804) 396-7886	

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency: Navy Bureau or Office: Norfolk Naval Shipyard Local Address (Including Zip Code): Portsmouth, Va 23709

FORM CA-16
(REV. DEC. 1974)

NAME (Print or type—Last, First, Middle Initial): Jones, Brandon E.

IDENTIFICATION NO.: 56-42876

ORGANIZATIONAL UNIT: Norfolk Naval Shipyard

FROM (Mo., Day, Hr.): 7/5/83 a.m. p.m.

TO (Mo., Day, Hr.): Continuing a.m. p.m.

NO. OF HOURS

TYPE OF LEAVE: ☐ ANNUAL—"I understand that any annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP." ☑ SICK—Complete other side of this form. ☐ WITHOUT PAY ☐ COMPENSATORY ☑ OTHER (Specify) COP + Comp

REMARKS: Hurt on the job

SIGNATURE OF EMPLOYEE: Brandon E. Jones

DATE: 7/9/83

INSTRUCTIONS: Complete above part of form. If applying for sick leave, check appropriate box on back (top) of form. If you were under care of a doctor, he should complete "CERTIFICATE OF PHYSICIAN OR PRACTITIONER" also on back.

OFFICIAL ACTION ON APPLICATION

☐ APPROVED ☐ DISAPPROVED (If disapproved, give reason)

SIGNATURE AND DATE

STANDARD FORM 71 Revised November 1965 71-108

APPLICATION FOR LEAVE

U.S. CIVIL SERVICE COMMISSION FPM Supp. 990-1

EMPLOYEE (If applying for sick leave)

DURING THIS ABSENCE I WAS: INCAPACITATED FOR DUTY BY: ☐ SICKNESS ☑ ON-THE-JOB INJURY ☐ OFF-THE-JOB INJURY ☐ PREGNANCY AND CONFINEMENT ☐ UNDERGOING MEDICAL, DENTAL, OR OPTICAL EXAMINATION OR TREATMENT

☐ REQUIRED TO CARE FOR A MEMBER OF MY FAMILY WITH A CONTAGIOUS DISEASE (Give name and relationship of member of family, and name of disease) ☐ REQUIRED TO BE ABSENT BECAUSE OF EXPOSURE TO CONTAGIOUS DISEASE (Give name of disease and circumstances of exposure)

CERTIFICATE OF PHYSICIAN OR PRACTITIONER

NAME OF EMPLOYEE: Brandon E. Jones

POSITION OCCUPIED: Pipefitter

REMARKS: At Elba Spain

PERIOD UNDER PROFESSIONAL CARE

FROM (Mo., Day, Year): 7/8/83

TO (Mo., Day, Year): Continuing

THE EMPLOYEE NAMED WAS UNDER MY PROFESSIONAL CARE DURING THE PERIOD STATED ABOVE. From the medical standpoint, his condition during this period was such that I considered it inadvisable for him to report to work.

SIGNATURE: William Harris DATE: 7/9/83

U.S. GOVERNMENT PRINTING OFFICE 1966 O—210-184

July 8, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.D. 20211

RE: Jones, Brandon E.

Dear Sir:

The above patient was first examined by me on 6/24/83. The patient's chief complaint was that of painful movement concerning the right arm particularly in the elbow area.

The patient was instructed on certain excercises, given a prescription for pain, and advised to return in 2 weeks.

Sincerely

s/ Wm. Harris MD

William Harris, M. D.

TURN TO THE NEXT PAGE.

Select the most basic medical question that needs to be resolved. Then turn to the page after your answer.

a. You need a medical report of the treatment of the 7/8 injury. The certificate of the physician does not have adequate information about this. Turn to page 80, Box 1.

b. Did the 7/8 injury contribute to the current disability? Turn to page 63, Box 2.

c. What work limitations, if any, have been imposed on the claimant? Turn to page 79, Box 4.

TASK BOOK
CONTROVERSION
JOHN CASE

You have already read the resource material needed to resolve this case. If you wish to refresh your memory, consult pages 21 - 31 in the Resource Book.

Review the following CA-1 and medical report on pages 59 - 61 to determine if this case should be controverted. Then turn to page 62 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☐ Male ☒ Female	4. Social Security Number
John, Irene R	2/11/40	☒ Female	563-01-7240

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: Number:
3705 W. Madison	N/A

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Chicago Bulk Mail Center 7500 W. Roosevelt Rd Chicago Ill 60130	Star Route #143

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents Wife/Husband ☒ Children Under 18 Years Old ☒	12. Employee's Occupation
10-4-83 8:00 ☐ AM ☒ PM	10/10/83		Clerk

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
lifting mail packs	hurt back

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.
I was sent home for I need complete bed rest

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Irene R. John
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
U.S. Postal Service

22. Bureau or Office

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
7504 W. Roosevelt Rd Forest Park Ill 60130

24. Regular Work Day
Begins 3:30 ☐ AM ☑ PM Ends 12:00 ☒ AM ☐ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*
10/4/83 ☐ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
10/4/83

29. Date and Hour Stopped Work *(mo., day, year)*
10/4/83

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*

31. 45 Day Period Begins *(mo., day, year)*

32. Pay Rate When Employee Stopped Work
$220.60 per wk.

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury
George Fortune

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☑ Yes ☐ No. If Yes, Furnish Detailed Report. Emt came back from lunch intoxicated

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
10/4/83

39. Name and Address of Physician First Providing Medical Care
Oak Park Hospital
318 W. Madison Oak Pk

40. Do Medical Reports Show Employee Is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☒ No. If No, Furnish A Detailed Explanation. Emt had alcohol on his breath and was slurring his words

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor	44. Title and Office Phone Number	45. Date *(mo., day, year)*
George Fortune	Supervisor Mails	10/5/83

OAK PARK HOSPITAL
Emergency Room Report

This 44 year old female was seen in the emergency room for acute low back pain. Patient states that she hurt her back lifting a mail sack. Patient lumbar spine X-rays were negative for fix. EKG revealed normal readings, eye, ear, nose and head exam was normal. Blood pressure was 100/90, chest was clear. Examination of the lumbar spine revealed acute muscle spasm upon rest. Patient's blood analysis revealed .189 level of alcohol concentration in the blood. Legal point of intoxication is 0.10.

Patient was given a prescription for muscle relaxants and pain medications, and advised to go home for bed rest 1 week and return for exam. Patient advised to refrain from taking medication until 8 hours have elapsed. Patient left emergency room accompanied by her husband.

Jose Hernandez, M.D.

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
JOHN CASE

Circle the letter of the answer which represents the best course of action to now take. Then turn to the page listed next to the answer you select.

a. The claim is to be controverted because the claimant was legally intoxicated and would not have been able to maintain her balance. Turn to page 80, Box 3.

b. The compensation specialist should get additional clarification from the attending doctor on how intoxication may have contributed to her accident. Turn to page 79, Box 3.

c. The claim cannot be controverted because the intoxication did not cause the injury. Turn to page 63, Box 1.

From page 62

1

Correct. The best answer is c. This case is not controvertible even though claimant was acutely intoxicated since it did not cause the injury.

Turn to page 64 to begin a new case.

From page 57

2

Correct. The most basic question is "did the 7/8 injury contribute to the current disability?" (If even a part of the current disability was caused by the work injury it is compensable.)

Turn to page 58 to begin the next case.

From page 49

3

No. It is not necessary to interview both parties in this case because the supervisor's description clearly indicated it was a work related incident.

Return to page 49 and make another selection.

From page 40

4

Correct. A medical report would not provide any information on the basis on which you are controverting this case, namely that it is not timely filed.

Turn to page 45 to begin a new case.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 1

Review the Resource Book, pages 11 - 13 if you need to. Then return to this page for instructions.

Review the CA-1 submitted by Roger C. Bass on pages 65 - 66 and answer the questions on page 67.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee *(Last, first, middle)*	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Bass. Roger C	2-1-50		019-16-9922

5. Employee's Home Mailing Address *(No., street, city, state, zip code)*	6. Home Telephone
716 Kent Road Pikesville, Maryland 61104	Area Code: 301 Number: 608-5149

7. Name and Address of Employing Agency	8. Place Where Injury Occurred *(e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)*
U S Post Office 7284 Pratt Street BALTIMORE, MD 60103	Opening Belt - 3rd work floor Pratt Street Post Office

9. Date and Hour of Injury *(mo., day, year)*	10. Date of This Notice *(mo., day, year)*	11. Dependents	12. Employee's Occupation
9/6/83 7:10 ☒ AM ☐ PM	9/6/83	Wife/Husband ☑ Children Under 18 Years Old ☐	Mailhandler

13. Cause of Injury *(Describe how and why the injury occurred)*	14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*
While leaning forward to loosen jammed mail on the conveyor belt, I hit my right Knee on the metal cross bar brace	Bruised right Knee

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Roger C. Bass
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

18. Witness' Signature	19. Witness' Address	20. Date Signed *(mo., day, year)*

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
U. S Postal Service	Pratt Street Post Office

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
7284 Pratt Street
BALTIMORE, MD 60103

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 6:30 ☑ AM ☐ PM Ends 3:00 ☐ AM ☑ PM	8	(S) (M) (T) (W) (T) F S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
9/6/83 7:10 ☑ AM ☐ PM	9/6/83	9/6/83 7:30 AM	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor At Time of Injury
9/7/83	$ 21,096 per yr	9/10/83 6:30 ☒ AM ☐ PM	C. E. Thomas

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee Is Disabled For Work?
9/6/83	Vincent P Haines 1108 Benson Road Columbia, MD 21062	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☑ No. If No, Furnish A Detailed Explanation.
I don't understand how the employee could trump his knee on the metal cross bar brace.

42. Does The Employing Agency Controvert Continuation of Pay? ☑ Yes ☐ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

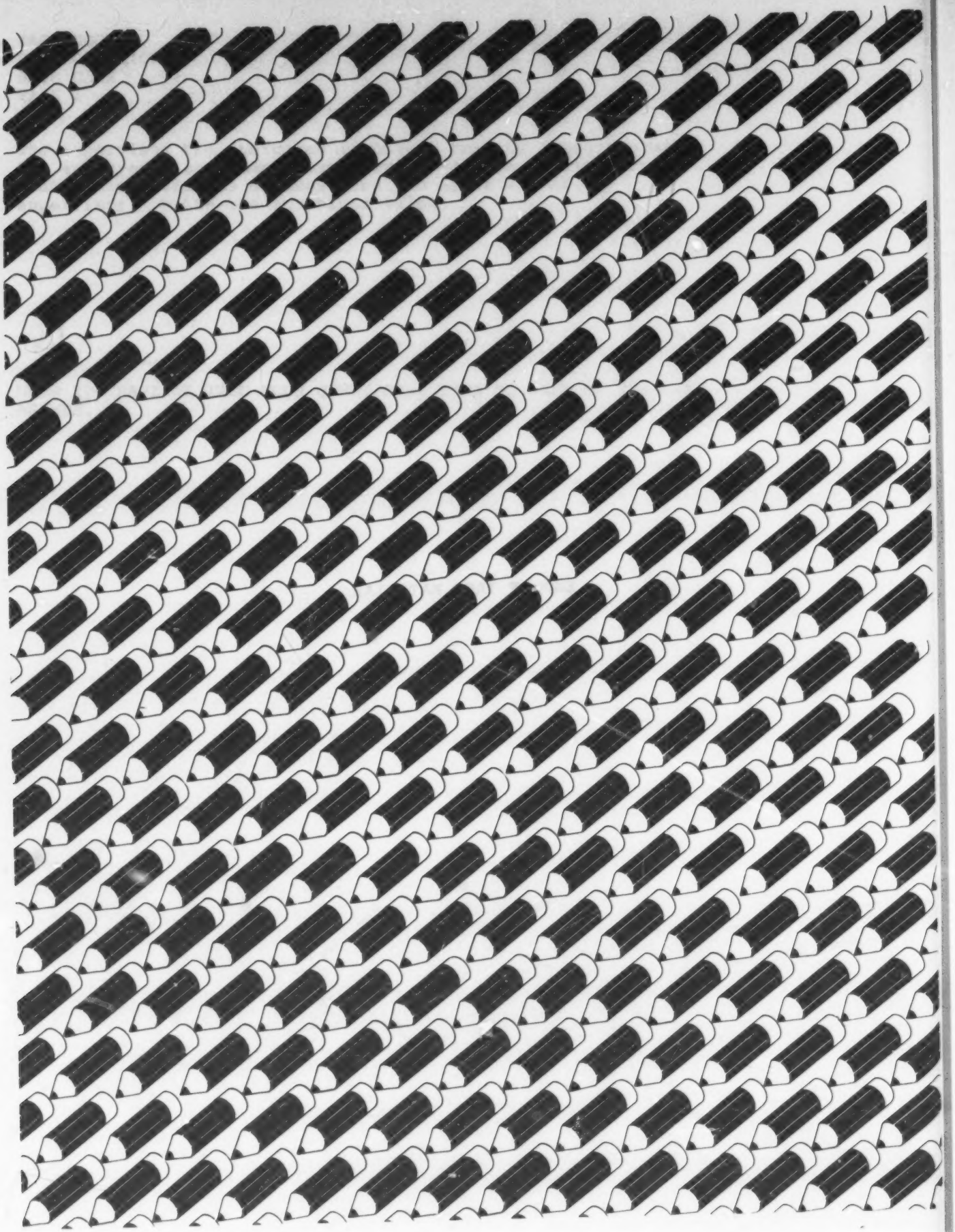
43. Signature of Supervisor	44. Title and Office Phone Number	45. Date *(mo., day, year)*
C. E. Thomas	301- Supervisor, Mails 9624	9/7/83

TASK BOOK
CONTROVERSION
BASS CASE
TASK 1

The supervisor has indicated in box 41 that he disagrees with the employee's statement, but provides little information. State three requests or questions you might ask of the supervisor. Write the questions below.

WHEN YOU HAVE WRITTEN YOUR QUESTIONS, TURN TO PAGE 68 FOR THE ANSWER.

END OF TASK MATERIAL



Answer:

Your request to Supervisor Thomas might contain any of the following points:

a. Please clarify your statement "I don't understand how the employee could bump his knee on the metal cross bar brace."

b. Please provide me with a detailed drawing of the conveyor belt. The diagram should be detailed, have labeled parts, and be easily understandable to the laymen. Please include any pertinent dimensions.

c. Were any other employees working on the belt with Mr. Bass at the time of injury? If so, have them provide a statement as to whether or not they witnessed the injury.

d. Was Mr. Bass' behavior or physical condition in any way different from the norm for the 40 minutes he worked prior to the injury?

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

Review the following statements you have received from Supervisor Thomas and witness Older and the diagram shown on page 72. Then complete the task on page 73.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

William I. Garcon
Injury Compensation Supervisor
Pratt Street Post Office
7284 Pratt Street
Baltimore, MD. 60103

Below is my itemized response to the questions you raised in your 9/8/83 memorandum:

1) The metal cross bar brace on which Mr. Bass alleges he struck his knee runs parallel to the floor and 10 inches above it. This is the only metal cross bar brace on the conveyor belt. Since mailhandler Thomas is 5'9" tall, it would be virtually impossible for him to strike his knee on the brace unless he was crouched down on both knees. To the contrary, Mr. Bass states he was leaning forward reaching across the machine to loosen jammed mail when he struck the knee. In this position it is impossible that he could strike the knee on the metal cross bar brace.

2) Enclosed is a diagram of the opening belt conveyer. I have identified the metal cross bar brace, given you the location of the individuals involved and also shown the position of the jammed mail on the belt.

3) Mailhandler Richard E. Older was approximately six feet away from Mr. Bass loading mail onto the belt. I have attached a copy of Mr Older's statement. This is a relatively quiet piece of equipment and conversation at six feet is audible.

4) I didn't notice anything unusual about Mr. Bass on the morning of injury. He showed none of the obvious signs of physical discomfort such as limping. He was on duty for only 40 minutes before the injury occurred.

5) I am not aware of any other factors pertinent to the merit of this claim. Mr. Bass drives a motorcycle to work and does play basketball.

6) Before I became a supervisor, I worked on the conveyer belt for eleven years. I know of no other employee ever injured in the manner described by Mr. Bass.

C. E. Thomas
Supervisor, Mails
Pratt Street Post Office

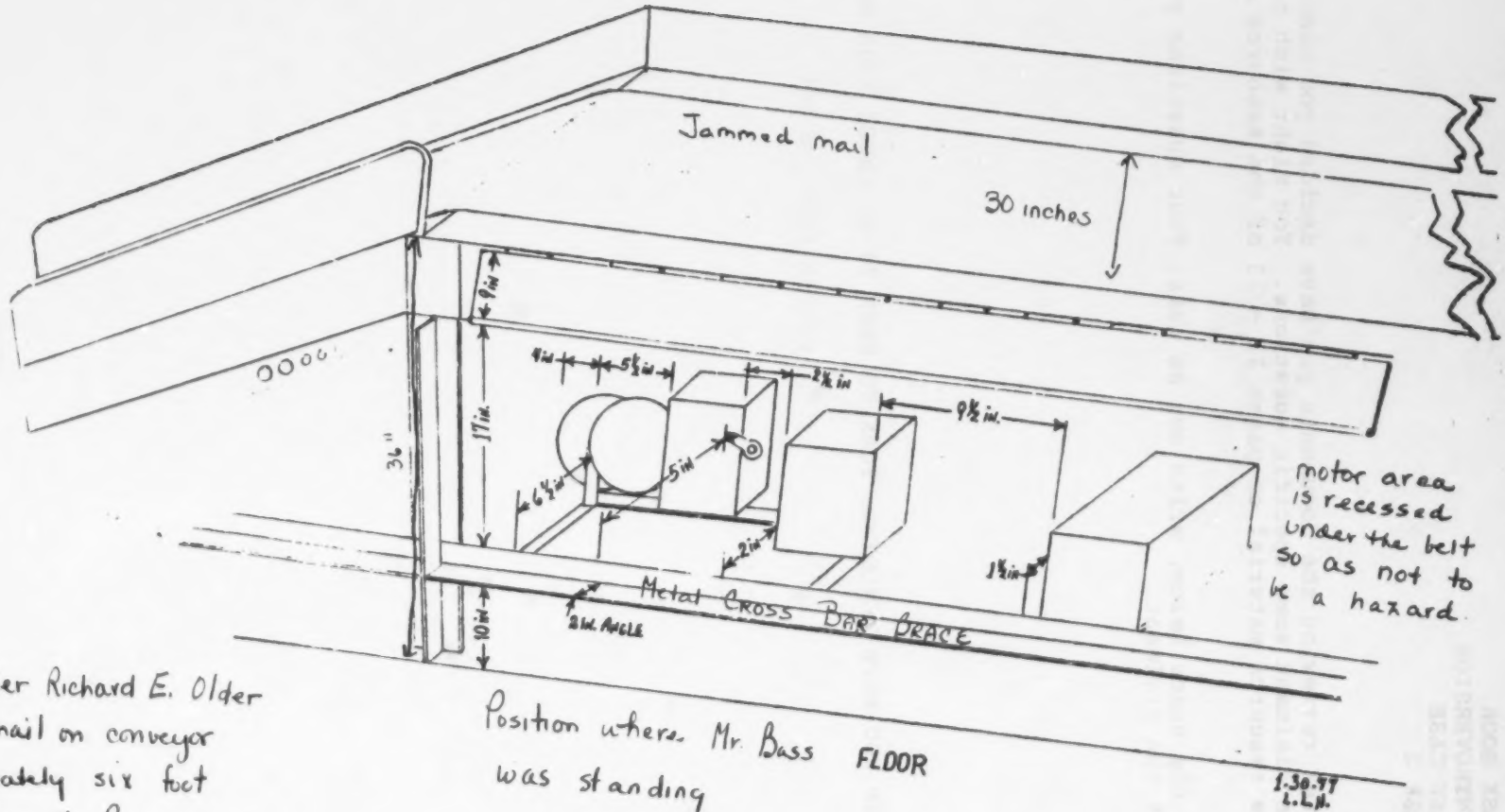
Attachments

TASK BOOK
CONTROVERSION
BASS CASE
TASK 2

TO: Supervisor C. E. Thomas
Pratt Street Post Office

On 9/6/83 at approximately 7:25 a.m. while working on #3 opening conveyor belt, I noticed Roger was limping. I asked him what happened and he told me that he bumped his knee a few minutes ago. I did not hear him holler or ask for help when it happened. This is all I know.

Richard E. Older
Mailhandler



Mailhandler Richard E. Older loading mail on conveyor approximately six feet away from Mr. Bass

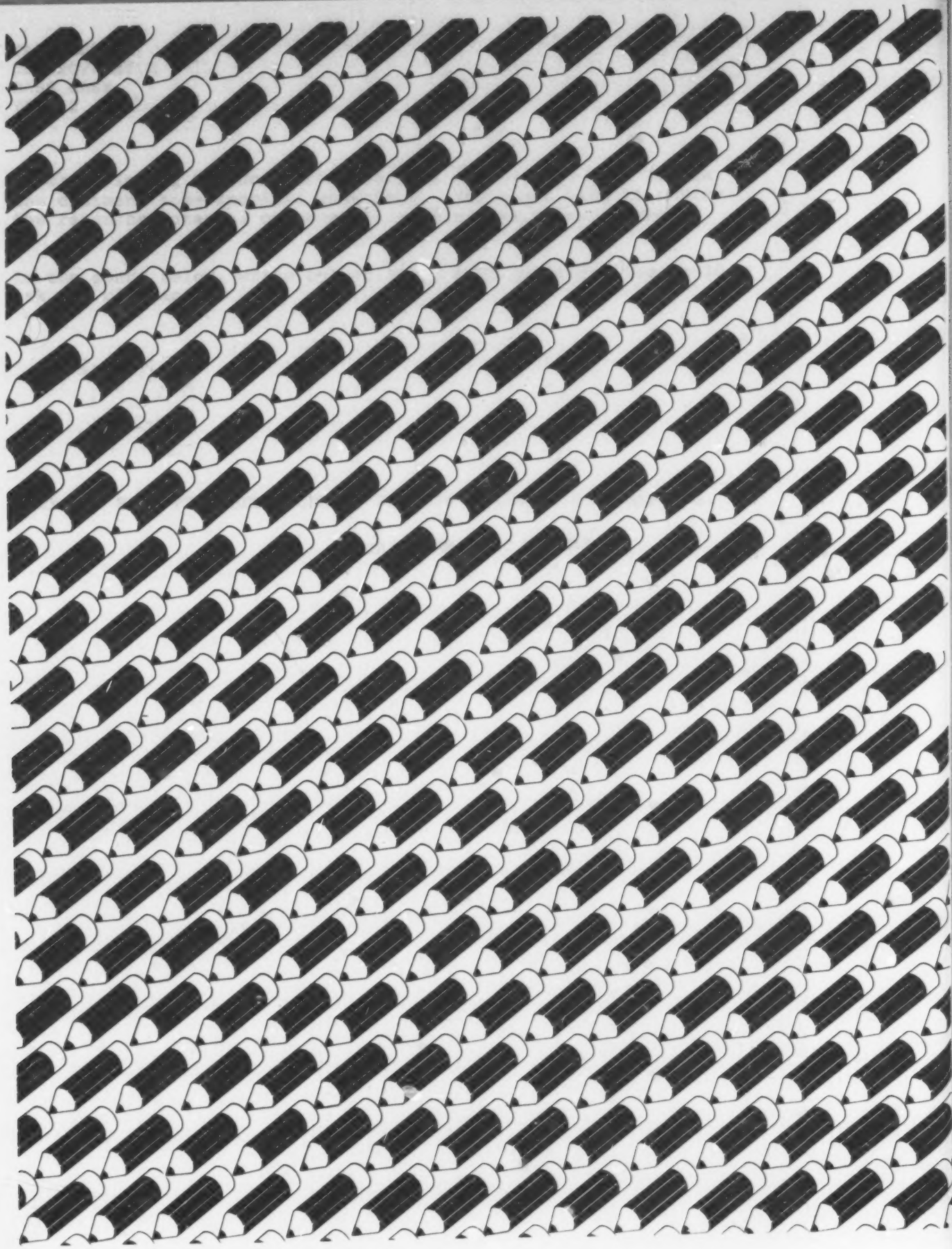
Position where Mr. Bass was standing

After reviewing the documents you have decided you need to ask the claimant some specific questions. You might wish to review the resource material on pages 11 - 13 of the Resource Book.

In the space below, write out at least four questions you would ask the claimant.

WHEN YOU HAVE FINISHED, TURN TO PAGE 74 TO CHECK YOUR ANSWERS.

END OF TASK MATERIAL



Answer:

The questions you might ask the claimant would include:

a. How did the injury occur? Give details.

   1. The corner bar brace is only 10" high. It appears that a man of your height would have had to slip or be in a squatting position to hit your knee. Are you sure you didn't slip?

   2. Did anything hit you from behind that would cause you to hit your knee?

You should ask the claimant the following questions, since OWCP will ask them anyway. To not supply the answers could hold up action on the claim.

b. Were there any persons who witnessed your injury or had immediate knowledge of it?

c. What were the immediate effects of the injury and what did you do immediately thereafter?

d. Was any other injury sustained, either on or off duty, between the date of injury and the date it was first reported to (a) your supervisor and (b) to a doctor? If so, describe:

e. Did you have any similar disability or symptoms before the injury? If so, describe the prior condition. Give the names and addresses of the physicians who treated you and the approximate dates you were treated:

f. Did you ever file a claim for workers' compensation benefits from any source? If so, give the date and nature of the injury, the name and address of the office where the claim was filed, and describe the benefits (if any) which you received.

TURN THE PAGE FOR THE NEXT TASK.

Read the answers to your questions from the claimant on the following pages (76 and 77).

STATEMENT

1. Describe in detail exactly how the injury occurred.

   A. I was working on the conveyor belt on September 6, 1983. When I leaned across to loosen some jammed mail, I hit my right knee on the metal cross bar brace.

a. The corner bar brace is only 10" high. It appears that a man of your height would have had to slip or be in a squatting position to hit your knee. Are you sure you didn't slip?

   A. No, I didn't slip. I was stretching across the conveyor belt. When I took a slight step forward to reach across I hit my knee.

b. Did anything hit you from behind that would cause you to hit your knee?

   A. Nothing hit me from behind.

2. Give the names of any persons who witnessed your injury or had immediate knowledge of it.

   A. There were no witnesses who saw the accident.

3. State the immediate effects of the injury and what you did immediately thereafter.

   A. My knee was hurting so bad, I told my supervisor I wanted to go to the doctor, so I went to my family doctor. He sent me home to put ice on my knee.

4. Was any other injury sustained, either on or off duty, between the date of injury and the date it was first reported to (a) your supervisor and (b) to a doctor? If so, describe:

   A. No.

(continued on next page)

Statement (continued)

5. Did you have any similar disability or symptoms before the injury? If so, describe the prior condition. Give the names and addresses of the physicians who treated you and the approximate dates you were treated.

   A. No.

6. Did you ever file a claim for workers' compensation benefits from any source? If so, give the date and nature of the injury, the name and address of the office where the claim was filed, and describe the benefits (if any) which you received.

   A. No.

s/ Roger C Bass

Roger C. Bass

GO ON TO NEXT PAGE.

TASK BOOK
CONTROVERSION
BASS CASE
TASK 3

On the basis of the claimant's answers, you decide to controvert the case. With that in mind, answer question a and turn to the page indicated.

a. Circle the number of the statement below which describes the grounds for controverting the case.

1. Failure to establish fact of injury. Turn to page 107, Box 1.

2. The condition is an occupational disease. Turn to page 80, Box 4.

3. The injury occurred off the employing agency's premises and the claimant was not involved in official duties. Turn to page 106, Box 3.

4. The claim was not timely filed. Turn to page 79, Box 2.

(If you need to review the grounds for controverting a claim, they are on pages 28 - 31 of the Resource Book.

b. Would you terminate COP? (Refer to the rules for controverting COP on pages 26 - 27 in the Resource if you need to.)

1. Yes. Turn to page 169, Box 4.

2. No. Turn to page 142, Box 2.

From page 49

1

Correct. This is the preferable course of action. This case is not controvertible due to the fact that the employee was involved in a fight over equipment at work. The fight arose out of the employment factors.

Now turn to page 51 for the next case.

From page 78

2

No. There is no evidence that the claim was not timely filed.

Return to page 78 for another choice.

From page 62

3

The Emergency Room report will not help because it is connected with the reported injury of lifting mail sacks.

Return to page 62 and select again.

From page 57

4

No. Work limitations should be requested later.. However, until you resolve the question of whether the disability is job-related, it is not really relevant.

Return to page 57 and try again.

From page 57

1

It is true that a complete medical report is needed and it must include what treatment was given for the 7/8 injury. However, this is not the most basic question.

Return to page 57 and select another answer.

From page 49

2

No. The description of the claimant, supervisor and medical report are consistent. The dates also match. There is no ground for questioning job relatedness.

Now return to page 49 and try a different answer.

From page 62

3

No. Even though the claimant was acutely intoxicated, it did not cause the injury. The Emergency Room report is connected with the reported injury of lifting mail sacks.

Return to page 62 and select a different answer.

From page 78

4

No. There is no evidence of an occupational disease.

Return to page 78 for another choice.

1

2

3

4

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

If you need to, review the Resource Book pages 28 - 33.

Review the CA-1 and CA-16 submitted on behalf of Sally A. Roberts on pages 82 - 85. Focus on what steps you would take with the case. After your review of those documents go on to page 86 which details next developments in the case.

best copy available

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☐ Male ☑ Female	4. Social Security Number
Roberts, Sally A	2-11-56	☑ Female	806-14-5407

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
711 Mountain Road Cockeysville, MD 21030	Area Code: 301 Number: 222-6081

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U S Postal Service 900 E Fayette St Balto MD 21233-9998	2nd workfloor - Operation 110

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
2/27/84 3:50 ☐ AM ☑ PM	2/27/84	Wife/Husband ☐ Children Under 18 Years Old ☐	Mail handler

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Harassment by supervisor over being late for work. Letter of warning issued to me	Nerves

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Sally A Roberts
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

None

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
U S PS	Balto Md

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
USPS - Rm 217
900 E Fayette St. Balto MD 21233-9408

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 3:30 ☐ AM ☑ PM Ends 12:00 ☑ AM ☐ PM	8	(S) (M) T (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
2/27/84 3:50 ☐ AM ☑ PM	2/27/84	2/20/84 3:50	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM	34. Name of Supervisor at Time of Injury
2/28/84	$ 16,036 per yr	HAS Not Returned	Wm X Black

35. Was Employee in Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee is Disabled For Work?
2/27/84	DR Michael R. Green 301 South Eutaw St Balto MD 21234	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☐ Yes ☑ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☑ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor	46. Title and Office Phone Number	47. Date *(mo., day, year)*
Wm X Black	Supvr. Mails	922-4930

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

DR Michael R. Green
301 South Eutaw St
BALTO MD 21234

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Roberts, Sally A	2/27/84	Mail handler

5. DESCRIPTION OF INJURY OR DISEASE

Employee alleges anxiety reaction over being disciplined for lateness

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☐ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☑ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Patricia L Short	Injury Comp Super.
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
922-4901	2/27/84

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.

Dept. or Agency 715 PS
Bureau or Office Balto Md.
Local Address (including Zip Code) 900 E Fayette St
Balto Md 21233-9408

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
Roberts Sally A

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
"Became emotionally upset over disciplinary action for lateness". Supervisor harasses me

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☑ Yes ☐ No No Roberts suffers from a paranoid mental disorder as a result of head trauma 2 yrs ago

17. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
anxiety reaction

18. WHAT IS YOUR DIAGNOSIS?
Paranoid mental disorder

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☑ Yes ☐ No May have been exacerbated by her P.O. job

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☑ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ Yes ☐ No

22. SURGERY (If any, describe type)
N/A

23. DATE SURGERY PERFORMED (mo., day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Counselling
psycho-therapy

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

26. DATE OF FIRST EXAMINATION (mo., day, year)
2/27/84

27. DATE(S) OF TREATMENT (mo., day, year)
2/27/84

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)
Has not

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 2/27 TO Unknown
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK
REGULAR WORK N/A

31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.

34. DO YOU SPECIALIZE? ☑ Yes ☐ No (If yes, state specialty) Psychiatrist

35. SIGNATURE OF PHYSICIAN
M.R. Green

36. ADDRESS (Number, street, city, state, zip code)
301 S. Eutaw St
Balto, Md. 21234

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
108-16-3601

38. DATE OF REPORT (mo., day, year)
2/28/84

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price Cost	Unit price Per	Amount $	Amount ¢
	TOTAL					

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TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

The supervisor checked "no" in block 41 of the CA-1, indicating his disagreement with the employee's description of the injury. But he did not furnish a detailed explanation. You request a written statement from him.

You also request a written statement from the claimant detailing the injury suffered.

Finally, you consult the Official Personnel File (OPF) for any similar incident in the past.

Review your notes from the OPF, statements from the claimant and the supervisor on pages 87 - 89.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

Your check of the personnel file reveals three letters of warning issued to Ms. Roberts in the past. Your notes summarizing these letters are:

1) Letter dated 12/4/83 - Given for lateness by supervisor Black

2) Letter dated 8/12/83 - Given for lateness by supervisor Johnson

3) Letter dated 4/8/83 - Given for lateness by supervisor Johnson

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

STATEMENT

On February 27 I got a letter from my supervisor that upset me so much that I had to see my doctor. Mr. Black threatened to suspend me. He terrified me so much that my nerves are shot. After I got the letter I tried to do my work, but I couldn't concentrate. I felt sick to my stomach and dizzy and couldn't stop crying. I went back to my supervisor and told him I wanted to see my doctor. I'm afraid to go back to work there. I just don't know what will happen next.

He's been hard on me all along, but now I know he's out to take my job away from me. I thought those other letters were mean and unnecessary. I believe he has been much harder on me than he should have been.

s/ Sally A. Roberts

Sally A. Roberts

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

STATEMENT

On 2/27/84 I issued a Letter of Warning to mailhandler Sally A. Roberts for lateness. In the past month Ms. Roberts has been late on seven different occasions. Prior to issuing the letter of warning, I had personalized private discussions with Ms. Roberts on 2/10/84 and again on 2/24/84 concerning her tardiness. I impressed on Ms. Roberts the importance of being punctual in that all scheduling is done within the first 15 minutes of the shift. Replacements are secured for employees who do not report and then, manpower overages occur when employees finally do report later in the tour. It was hoped that by explaining the scheduling process to Ms. Roberts she would be more conscientious in her efforts to report to work on time. Unfortunately, this did not occur. The first occasion that she was late after our 2/24/84 discussion was on 2/26/84 and I felt it necessary to give her a letter of warning on 2/27/84.

The Letter of Warning stated that continued lateness would not be tolerated and further instances would result in more severe disciplinary action such as suspension. The letter was discussed with Ms. Roberts in a private setting and at the end of our conversation she appeared to be completely rational.

Approximately 20 minutes later Ms. Roberts returned to my office in a highly agitated state. She stated that I was harrassing her and that she wanted to see her private doctor. At that point, I authorized her to go to the Medical Unit.

For the record, Ms. Roberts has received a personal Letter of Warning from me in the past year. At that time it did not result in her having an anxiety attack.

s/ Wm Black

William X. Black
Supervisor, Mails

TURN THE PAGE.

TASK BOOK
CONTROVERSION
ROBERTS CASE
TASK 1

Based on your review of these documents, circle the letter in front of one or more of the following steps listed below that you would take:

a. Request that the claimant re-submit the claim on a CA-2

b. Controvert the claim on the basis of failure to establish fact of injury.

c. Process the claim (don't controvert) on the basis of medical condition of an aggravation.

d. Controvert the claim on the basis that it is an occupational disease claim, not a traumatic injury.

e. Withhold any action until you have received a fully detailed medical report including a complete diagnosis and sound medical opinion that the medical condition is job related.

f. Controvert the claim on the basis of pre-existing condition not related to work.

g. Controvert COP.

WHEN YOU HAVE MADE YOUR SELECTION(S) TURN TO PAGE 91 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

Answer:

You should have circled items a, d, and g, (Request that the claimant re-submit the claim on a CA-2, controvert the claim on the basis that it is an occupational disease claim, not a traumatic injury, and controvert COP)

You have a case for controversion on the basis that this is an occupational disease claim. Even though Sally Roberts did not react violently to previous letters of warning, the cause of her symptoms was the underlying environmental condition (alleged harrassment) which has been going on for 10 months. As a result it is an occupational disease, not a traumatic injury.

You would therefore terminate COP and request that she submit a CA-2.

b. The fact of injury (anxiety attack) is admitted by supervisor as claimed.

c. An aggravation may indeed turn out to be the case after sufficient medical evidence is developed since the attending physician indicates this. However, it is still probably an occupational disease case and the traumatic injury claim with COP should be controverted.

e. Sure a medical report should be requested, but on the evidence you judge that it is an occupational disease case, you should not wait before taking steps a, d, and g.

f. Even though a pre-existing condition is present, the doctor indicates that there may be an aggravation which would be compensable.

YOU HAVE FINISHED THE MODULE ON CONTROVERSION.

IF YOU WISH TO CONTINUE NOW, TURN THE PAGE TO BEGIN A NEW MODULE.

MODULE III

THIRD PARTY

As in the previous modules, you will be given a case and a series of tasks. For the case in this module you will be asked to:

a. Make an initial decision about the case on the basis of the information given, and

b. Compute or evaluate any additional information.

TURN THE PAGE TO DO THE CASE ON THIRD PARTY LIABILITY.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 1

First read the Resource Book, pages 35 - 36 (through No. 10)

Then review the following CA-1 to determine if there is possible third party liability. Go to page 96 to answer the question.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3.	4. Social Security Number
Williams, Arlene S	6-17-40	☐ Male ☑ Female	128-14-7010

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
893 McCullough Street, BALTIMORE, MD 21015	Area Code: 301 Number: 646-1983

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U S Postal Service 1900 E Fayette Street Baltimore, MD 21233	Intersection of 8th and Market Street

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
6/10/83 2:15 ☐ AM ☒ PM	5/16/83	Wife/Husband ☑ Children Under 18 Years Old ☑	Letter Carrier

13. Cause of Injury *(Describe how and why the injury occurred)*

Stopped at the intersection of 8th and Market Street when a truck drifting backwards hit the front of my vehicle

14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*

neck sprain

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

I was taken from the accident scene to the hospital. Then I was home on bedrest. Today is my first day back to work

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Arlene S Williams
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
U S Postal Service

22. Bureau or Office
Baltimore, Maryland

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
1900 East Fayette Street
Baltimore Md 21233

24. Regular Work Day
Begins 6:00 ☒ AM ☐ PM Ends 2:30 ☐ AM ☒ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*
5/10/83 2:15 ☐ AM ☒ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
5/10/83 (Verbal)

29. Date and Hour Stopped Work *(mo., day, year)*
5/10/83 2:15 P.M

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
N/A

31. 45 Day Period Begins *(mo., day, year)*
5/11/83

32. Pay Rate When Employee Stopped Work
$ 22.040 per yr

33. Date and Hour Employee Returned to Work *(mo., day, year)*
5/16/83 8:30 ☒ AM ☐ PM

34. Name of Supervisor At Time of Injury
Mae L. Marts

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
5/10/83

39. Name and Address of Physician First Providing Medical Care
Union Hospital
409 Greenway Avenue
Baltimore, Maryland 21110

40. Do Medical Reports Show Employee Is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Mae R Marts

44. Title and Office Phone Number
252-6048
Supervisor, Delivery

45. Date *(mo., day, year)*
5/16/83

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 1

Circle the letter of the choice below that most nearly describes what the indicator of third party liability in this case is:

a. The cause of the injury was defective equipment for which the manufacturer may be responsible. Turn to page 142, Box 3.

b. You always know that it is a third party case if there is an automobile accident. Turn to page 107, Box 2.

c. There is no indicator of third party liability. Box 37, "Was Injury Caused by Third Party? was checked NO. Turn to page 141, Box 3.

d. The indicator is the statement made on the CA-1, block 13 which says "a truck drifting backwards hit the front of my vehicle". Turn to page 106, Box 4.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 2

How would you verify that there is, in fact, third party liability? Again, circle the letter of the statement that best describes your answer and turn to the page indicated next to your answer.

a. Interview the driver of the other vehicle to get the facts about the injury. Turn to page 107, Box 3.

b. Interview any witnesses to the accident and get statements about what they saw. Turn to page 141, Box 4.

c. Get the police report to see if the driver of the truck was cited by the police as being responsible for the accident. Turn to page 106, Box 1.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 3

Read the Resource, pages 36 - 40.

You have obtained the police report. It says that the truck driver was cited for the accident and there is nothing to indicate any contributory negligence.

The agency is now pursuing this claim. Review the following correspondence on the case from pages 99 - 104.

Then do the task on page 105.

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233
May 17, 1983

Ms. Arlene A. Williams
893 McCullough Street
Baltimore, MD 21015

Dear Ms. Williams:

Our records show that on May 10, 1983 you sustained an injury under circumstances which may place liability for damages on a party other than the United States.

Under the provisions of Section 8131 of Title 5, United States Code, the Secretary of Labor can and will require a workers' compensation beneficiary to prosecute an action for damages in his/her own name when injury or death occurs under circumstances which indicate legal liability to pay damages on a party other than the government. When damages are recoverd from such a party, the beneficiary must, out of the damages recovered, reimburse the United States for any payments made to the beneficiary or on the beneficiary's behalf. Nevertheless, in all cases you will be entitled to a minimum of 20% of the net recovery.

For our records a statement is required from you as to whether you have presented a claim for damages as a result of this injury against anyone other than the Postal Service or the Office of Workers' Compensation Programs. It is requested that you answer the questions on the attached form, Third Party Claim-Information Request, and promptly return it to this office.

If you have initiated a third-party action, you should contact us for a statement of any COP and OWCP disbursements made to you or on your behalf before you make a final settlement. These disbursements must be repaid from any recovery you make from the third party (the person or persons responsible for the injury).

If you wish to discuss this matter or desire us to assist you, please contact me on 938-6012.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor.

U.S. POSTAL SERVICE
INJURY COMPENSATION PROGRAM – NOTICE OF POTENTIAL THIRD PARTY CLAIM
(See instructions on reverse)

1. DATE: 5-24-83

2. Name of Employee: Arlene S. Williams

3. Home Phone (Include Area Code): (301) 646-1983

4. Home Address (Include Apt. No. and ZIP Code): 893 McCullough Street Baltimore Md. 21215

5. Type of Injury: Motor Vehicle Accident

6. Date and Location of Injury: 5-16-83 8th and Market Street Baltimore Md. 21233

7. Office of Employment: U.S Postal Service

8. Employee's Title: Letter Carrier

9. Contact Point at Employing Office (Name and Phone): Mae L. Marts 252-6048

10. Employee's Social Security No.: 128-14-7010

11. Prepared by (Printed Name and Signature): Arlene S. Williams

12. OWCP File No.: A25-169803

13. Brief Description of Incident:

While stopped at intersection of 8th and Market a truck drifting backwards hit the frmt of the mail vehicle.

14. Does the Employee or Beneficiary(ies) intend to take action against the Third Party?
☒ YES ☐ NO (If "No", specify why not)

15. Third Party
a. Name: Larry R. Wilson

b. Address (Include Apt. No. and ZIP Code): 1108 15th Street Baltimore Md. 21215

c. Name and Address of Insurance Company (Include Suite No.): Ashley Insurance Co. P.O. Box 6128 Baltimore Md. 21151

16. Name and Address of Attending Physician (Apt./Suite No.): Dr. Alexander Gee Union Hospital 409 Greenway Ave. Balt. Md. 21218

17. Law Enforcement Agency Notified: Baltimore Police Dept.

18. Name and Address of Attorney representing employee in Third Party Action (Include Apt./Suite No.)

19. EMPLOYEE OR REPRESENTATIVE

Wage records, medical records, and other pertinent information may be released to my attorney. ☒ YES ☐ NO

a. Date Signed	b. Printed Name	c. Signature
5/24/83	Arlene S Williams	Arlene S. Williams

PS Form 2562
Mar. 1981

U.S. POSTAL SERVICE

ASSIGNMENT OF CLAIM TO THE USPS

As a result of my applying for and receiving benefits under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101-50), and because I do not wish to prosecute an action in my own name to recover damages, I (name) Arlene S Williams, of (address) 893 Mc Cullough Street, City of Baltimore, County of _____, State of Md., hereby voluntarily assign to the United States Postal Service all of my right, title and interest in any claim, demand, or cause of action which I may have against (name of third party) Larry R. Wilson, or any other person, as a result of an injury I sustained on (date) 5/16/83, at (location) 8th and Market Street Baltimore, Md., while in the performance of my duties as an employee of the United States Postal Service.

I understand that in the event of recovery of damages by the United States Postal Service under this assignment, I am entitled to one-fifth of the net amount of recovery after the expenses thereof have been deducted and to any surplus remaining as provided by Section 8131 of the Federal Employees' Compensation Act.

I understand that I have the right to pursue an action to recover damages by myself or by an attorney of my own choice, but I hereby am assigning that right to the United States Postal Service. Upon acceptance of this assignment, the United States Postal Service shall have full and complete authority to take whatever action on this claim it considers appropriate, and may institute legal action, settle or compromise the claim or any suit, or decline to institute suit, or to take any other action.

I hereby authorize the United States Postal Service to furnish all records, medical and other reports, statements made by myself and other papers relating to my injury to the parties against whom claim is made, their representatives, and insurance companies for the purpose of effectuating a settlement of the assigned claim.

IN WITNESS WHEREOF, I have signed this assignment this 24th day of May, 1983.

Arlene S. Williams
(Signature)

Pursuant to the authority granted by 39 C.F.R. 224.2(b) (1) (i) and other Postal Regulations, I hereby accept the above assignment.

Dated 5-25-84

Mary A Elliott
(Signature)

Injury Compensation Sup.
(Title)

PS Form 2577
Feb. 1981

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233

May 25, 1983

Mr. Larry R. Wilson
1108 15th Street
Baltimore, MD 21015

Dear Mr. Wilson:

On 5/10/83, a postal employee, Arlene S. Williams, was injured as a result of your truck drifting backwards into the front of her postal vehicle.

Pursuant to the provisions of the Federal Employees' Compensation Act, our employee has filed for benefits and has assigned her personal injury claim to the Postal Service. A copy of that assignment is attached.

We request that you, your insurance carrier, or your attorney contact this office to discuss settlement of this matter.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor.

UNITED STATES POSTAL SERVICE
MANAGEMENT SECTIONAL CENTER
BALTIMORE, MD. 21233
June 15, 1983

TO: Mae L. Marts, Supervisor, Delivery
USPS
1900 E. Fayette Street
Baltimore, MD 21233

SUBJECT: Third Party Claim

Employee: Arlene S. Williams
OWCP Claim No.: A25-169803
Date of Injury: 5/10/83

Please be advised that we anticipate negotiating settlement with respect to the captioned case in the near future. Therefore, it is requested that you discuss this matter with the employee to determine if there are any expenses, other than those listed below, that were incurred as a result of this injury, which the employee wishes taken into consideration at the time of settlement. Such expenses may include pain and suffering, damage expenses not covered by COP or FECA benefits.

If any such expenses exist, please furnish this office an itemized statement by 6-28-83 so that we may fully document our file before any settlement negotiations are finalized.

Your cooperation in this matter is appreciated.

Sincerely,

Mary Y. Elliott
Injury Compensation Supervisor

MEDICAL AND RELATED EXPENSES:

Name of Provider:	Amount:
Union Hospital	$ 184.00
Dr. Alexander Gee	$ 110.00
Prescriptions	$ 15.84
Cervical Collar	$ 11.00
Subtotal	$ 320.84

CONTINUATION OF PAY:

From: 5/11/83 To: 5/15/83	Amount:
	$ 342.68

OTHER:

DISBURSEMENTS MADE BY THE
OFFICE OF WORKERS' COMPENSATION PROGRAMS
AND BY THE EMPLOYING AGENCY
JULY 18, 1983

NOTE: ADDITIONAL PAYMENTS MAY BE MADE. THEREFORE, PLEASE CONTACT THIS OFFICE FOR AN UP-TO-DATE STATEMENT PRIOR TO FINAL SETTLEMENT OF THE THIRD PARTY ACTION.

CLAIMANT: Arlene S. Williams
FILE NO: A25-680139
DATE OF INJURY: 5/10/83

CONTINUATION OF PAY		
From: 5/11/83	To: 5/15/83	$ 342.68
	Subtotal	$ 342.68

COMPENSATION PAYMENTS		
From:	To:	$
	Subtotal	$

MEDICAL AND RELATED EXPENSES

Name of Provider	Amount
Union Hospital	$ 184.00
Dr. Alexander Gee	$ 110.00
Prescriptions	$ 15.84
Cervical Collar	$ 11.00
Subtotal	$ 320.84

DISBURSEMENTS TO DATE $ 663.52

Prior to figuring the lien, you review the file and notice that an important piece of information is missing from the file. Circle the letter of the item that is missing from the file and read the page indicated for the answer.

a. Correspondence to the third party explaining the accident and asking that responsible party, insurance carrier or their attorney contact the workers' compensation office to discuss the case. Turn to page 107, Box 4.

b. A statement from OWCP providing itemization of disbursements made on behalf of the claim. Turn to page 142, Box 4.

c. Correspondence to the employee's supervisor requesting that she ask the employee if there are any expenses other than those you list in that letter that were incurred as a result of the injury which the employee wants included in the settlement. Turn to page 106, Box 2.

d. Response from the employee's supervisor indicating if there are any other expenses that the employee incurred. Turn to page 141, Box 1.

From page 97

1

Correct. Get the police report to see if the driver of the truck was cited by the police as being responsible for the accident. If he were, this would clearly determine liability.

NOW, IF YOU WORK FOR THE U. S. POSTAL SERVICE OR ANOTHER AGENCY THAT HAS ARRANGED WITH OWCP TO PURSUE ITS OWN CLAIMS, TURN TO PAGE 98 TO CONTINUE THIS CASE. IF YOUR AGENCY DOES NOT PURSUE ITS OWN CLAIMS, GO ON TO PAGE 114 TO BEGIN THE MODULE ON LIGHT DUTY. IF YOU DO NOT WORK FOR THE USPS AND YOU ARE NOT SURE IF YOUR AGENCY HAS SUCH AN AGREEMENT, ASSUME THERE IS NONE AND GO TO PAGE 115.

From page 105

2

No. This correspondence is in the file.

Return to page 105 for another try.

From page 78

3

No. Even though you may conclude that it was impossible for the injury to occur as the claimant described, you have no evidence that the injury resulted from an off-premises injury.

Return to page 78 for another try.

From page 96

4

Correct. The best answer is "the statement made on the CA-1." There appears to be third party liability, even though the question in block 37 was checked "no". It appears that the driver of the truck is responsible for the accident and the resulting injury to the letter carrier.

Turn to page 97 for the next task.

From page 78

1

Correct. The grounds are failure to establish fact of injury (#1).

Return to page 78 and answer question b.

From page 97

2

No, although an automobile accident can mean third party liability, that is not always the case. This has to be checked out. In this case, the claimant's statement on the CA-1 gives you an indicator that there may be third party liability.

Return to page 97 and try again.

From page 97

3

No. The driver of the other vehicle may be willing to be interviewed by you, but even if he does, would the results be considered objective?

Return to page 97 for another try.

From page 105

4

No. that is in the file.

Return to page 105 for another try.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 4

You have received the piece of missing information. It follows on page 109.

From it and the information in the file figure:

a. The lien

$_____

b. The projected settlement figure

$_____

AFTER YOU HAVE ARRIVED AT YOUR ANSWER, COMPARE YOURS WITH THE ANSWER ON PAGE 110.

MEMORANDUM
June 20, 1983

TO: Mary Y. Elliott
Injury Compensation Supervisor

FROM: Mae L. Marts
Supervisor, Delivery

SUBJECT: Employee: Arlene S. Williams
OWCP Claim No.: A25-169803
Date of Injury: 5/10/83

In response to your request regarding expenses incurred as a result of her injury, Ms. Williams has itemized the expenses below:

MEDICAL AND RELATED EXPENSES:

Name of Provider:	Amount:
Union Hospital	$ 184.00
Dr. Alexander Gee	$ 110.00
Prescriptions	$ 15.84
Cervical Collar	$ 11.00
Subtotal	$ 320.84

CONTINUATION OF PAY:

From: 5/11/83 To: 5/15/83	Amount:
	$ 342.68

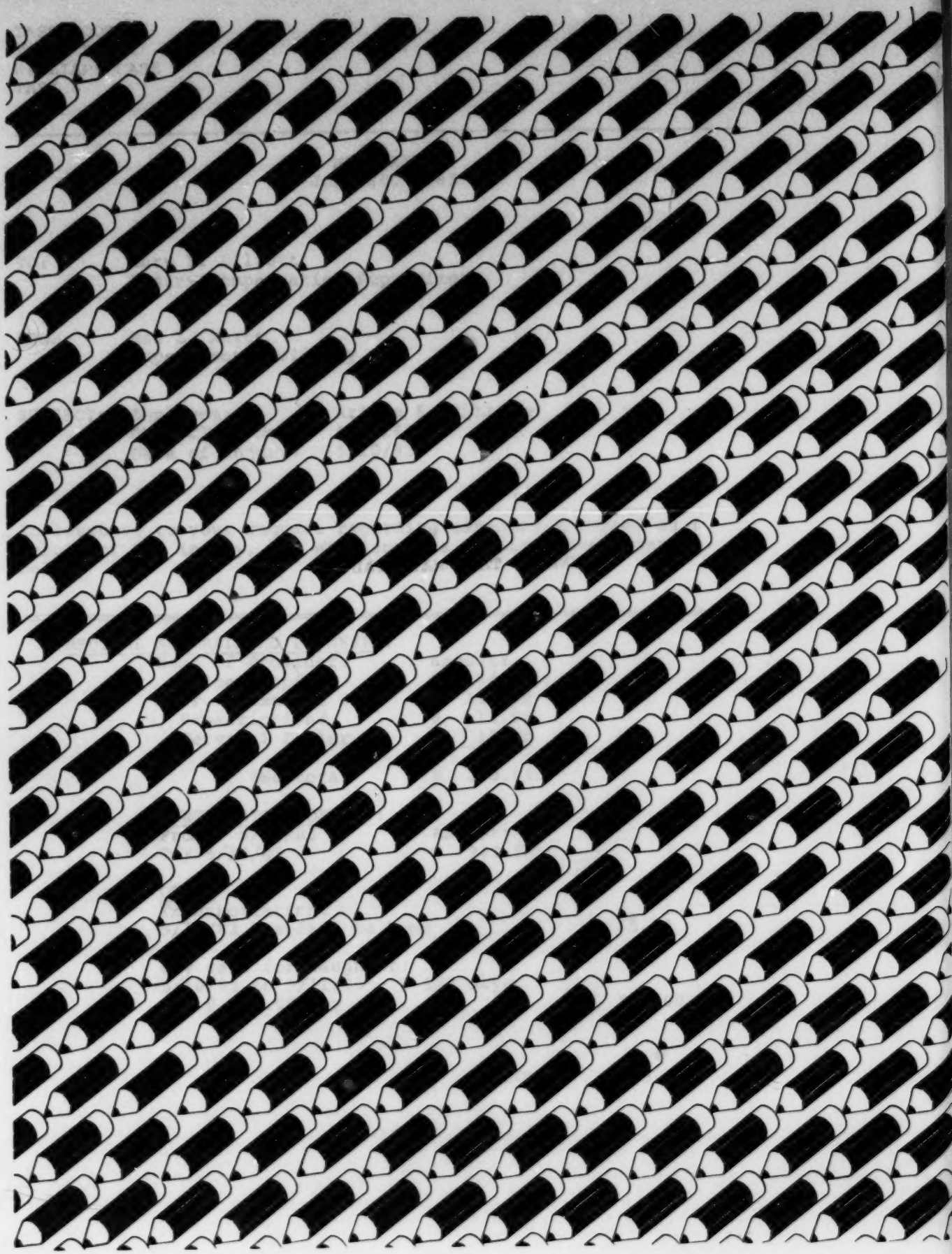
OTHER

Transportation:
5/11/83 hospital to home $5.00

Day care for daughter:
5/10/83 to 5/11/83 - 1 1/2 days
@ $20.00/day $30.00

TOTAL $35.00

END OF TASK MATERIAL



TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 4

Answer:

a. Lien is $698.52 (or $699)

This is taken from the Disbursements notification by OWCP - $663.52 plus expenses incurred by the employee submitted on the memo from the employee's supervisor - $35.00. Total of these two figures equals $698.52.

b. Projected settlement figure is $2,096.

This was arrived at by multiplying the lien of $698.52 times 3 since this is a minor injury. Total of this is $2,095.56. Round it up to the nearest dollar to get $2,096.

TURN THE PAGE AND DO THE LAST TASK FOR THIS CASE.

TASK BOOK
THIRD PARTY
WILLIAMS CASE
TASK 5

Using the figures from the previous task, complete the Statement of Recovery on page 112. Instructions for completing this Statement of Recovery are on page 113.

WHEN YOU HAVE COMPLETED THE FORM, COMPARE YOUR FIGURES WITH THOSE IN THE BOOK ANSWER ON PAGE 114.

STATEMENT OF RECOVERY

Claimant: **File Number:**

Date of Injury/Death: **Employing Agency:**

(1)	Gross Recovery		$_____
(2)	Less Property Damage		_____
(3)	Balance		_____
(4)	Less Attorney's Fee (Fee is _____% of line 3)		_____
(5)	Balance		_____
(6)	Less Court Costs (must be itemized)		_____
(7)	Balance (Adjusted Gross Recovery)		_____
(8)	Less 1/5 (20% of line 7)		_____
(9)	Balance		_____
(10)	Continuation of Pay (COP)		_____
(11)	Balance		_____
(12)	Less Payment to Public Health Service (or other Federal medical facility)		_____
(13)	Balance		_____
(14)	Less Medical Expenses Paid by the Claimant (must be itemized)		_____
(15)	Balance		_____
(16)	OWCP Disbursements (including compensation and medical but excluding COP) or line 15 above, whichever is less	$_____	_____
(17)	Less Government Allowance for Attorney's Fee (retained by claimant)	_____	
(18)	Net OWCP Refund	_____	
(19)	Plus Continuation of Pay (line 10)	_____	
(20)	Total Refund	_____	
(21)	Surplus (line 15 less line 16)		_____

Form CA-162
Rev. August 1980

INSTRUCTIONS

Distribution must be made in accordance with 5 U.S.C. 8132.

PROPERTY DAMAGE (Line 2) A reasonable amount for clothing or other personal belongings damaged or destroyed in an accident may be deducted. These amounts should be itemized. If an automobile or other vehicle is damaged or destroyed, then more tangible evidence of such damage is required. The year, make and model, and the Blue Book value of the vehicle should be furnished. A copy of the repair bill will suffice if the vehicle was not totally destroyed.

ATTORNEY'S FEE (Line 4) The attorney's fee in line 4 is deducted from the balance shown in line 3. Also, the attorney's fee as a percentage of line 3 should be shown.

COURT COSTS (Line 6) These would consist only of such items as filing fees, witness fees, actual costs of collection, or any payments to physicians for expert testimony as opposed to payment for treatment. (Payment for medical treatment would come under line 12 and/or 14.) All items must be itemized.

20% GUARANTEE (Line 8) This amount is turned over to the claimant and is not subject to any deductions.

CONTINUATION OF PAY (COP) (Line 10) If pay was continued by the employing agency as provided by 5 U.S.C. 8118, the employing agency is entitled to be reimbursed out of any third party recovery resulting from the employment-related injury. The OWCP will collect the COP as the agent of the employing agency.

PUBLIC HEALTH SERVICE (Line 12) Refund made to a Federal medical facility for medical treatment would be deductible under line 12. The claim of the Federal medical facility is separate and apart from the claim of the OWCP.

MEDICAL EXPENSE PAID DIRECT (Line 14) This would consist of any medical expenses paid by the claimant other than those paid by the OWCP or by an insurance carrier. It would not include items paid by the claimant for which the claimant subsequently was reimbursed by the OWCP or an insurance carrier. All items submitted for credit and deduction in line 14 must be itemized or accompanied by copies of paid bills. A lump sum amount will not be accepted for credit.

GOVERNMENT ALLOWANCE FOR ATTORNEY'S FEE (Line 17) The Government contributes a portion of its refund to the claimant as an attorney's fee. This fee is based upon the OWCP's disbursements or other amount as shown in line 16 and is computed by applying the percentage shown in line 4 to line 16 if line 4 is considered reasonable.

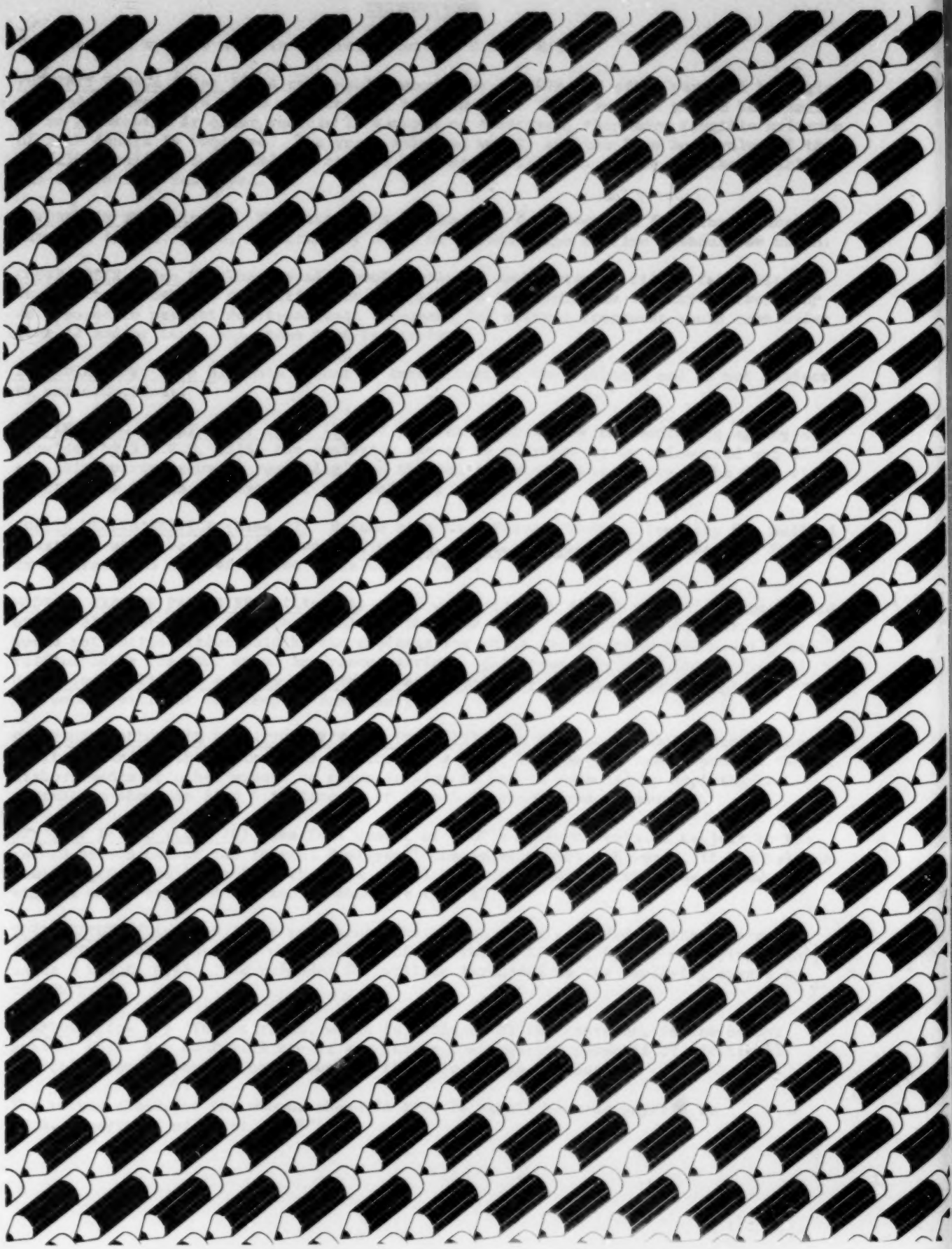
NET OWCP REFUND (Line 18) The full amount of OWCP's disbursements is subject to the refund provisions of the Federal Employees' Compensation Act. However, if the balance remaining in line 15 is less than the actual OWCP disbursement, then the refund provisions would apply to the amount shown in line 15.

TOTAL REFUND (Line 20) This represents the amount to be refunded to the Government for OWCP disbursements and continuation of pay (COP), if any, by the employing agency under 5 U.S.C. 8118. The refunded COP will be forwarded to the employing agency by the OWCP.

SURPLUS (Line 21) This surplus, which is retained by the claimant, is the amount against which the OWCP will credit any future compensation payments or additional medical expenses payable on account of the same injury or death.

The refund check for the amount shown in line 20 should be made payable to "U.S. Department of Labor, OWCP".

END OF TASK MATERIAL



ANSWER:

STATEMENT OF RECOVERY
(see reverse for instructions)

Claimant: Arlene S. Williams **File Number:** A25-680139

Date of Injury/Death: **Employing Agency:** USPS

(1)	Gross Recovery		$ 2096.00
(2)	Less Property Damage		-
(3)	Balance		2096.00
(4)	Less Attorney's Fee (Fee is ____% of line 3)		-
(5)	Balance		2096.00
(6)	Less Court Costs (must be itemized)		-
(7)	Balance (Adjusted Gross Recovery)		2096.00
(8)	Less 1/5 (20% of line 7)		419.20
(9)	Balance		1 676.80
(10)	Continuation of Pay (COP)		342.68
(11)	Balance		1 334.12
(12)	Less Payment to Public Health Service (or other Federal medical facility)		-
(13)	Balance		1 334.12
(14)	Less Medical Expenses Paid by the Claimant (must be itemized)		-
(15)	Balance		1 334.12
(16)	OWCP Disbursements (including compensation and medical but excluding COP) or line 15 above, whichever is less	$ 320.84	
(17)	Less Government Allowance for Attorney's Fee (retained by claimant)	-	
(18)	Net OWCP Refund	320.84	
(19)	Plus Continuation of Pay (line 10)	342.68	
(20)	Total Refund	663.52	
(21)	Surplus (line 15 less line 16)		$ 1013.28

TURN THE PAGE TO BEGIN A NEW MODULE

Form CA-162
Rev. August 1980

MODULE 4

LIGHT DUTY

As in the previous modules, you will be given a case and a series of tasks. For each case you will be asked to:

a. Make one or more decisions

b. Decide whether or not to place the claimant in a light duty position, and

c. If so, what kind of position.

TURN THE PAGE TO BEGIN THE FIRST CASE.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

Read the Resource Book, pages 43 - 47.

Review the medical report on page 117 from Dr. Lawhorn concerning Jack A. Davidson. Jack has been off work for over a year due to a job-related injury and is receiving compensation for total temporary disability from OWCP. Also review the the physical requirements of his carpenter's job on page 118. Then go to the worksheet on page 119 and do the task.

Phillip D. Lawhorn, M. D.
Orthopedics
201 East Main Street
Muscle Shoals, Alabama

March 22, 1984:

RE: Jack A. Davidson

Jack returns today as scheduled. He states he has been doing well and has little pain unless he uses his left arm a great deal. Examination reveals a well-healed shoulder scar at the site of the surgical repair of his torn rotator cuff. His range of motion is limited. I believe Jack has reached a maximum point of recovery from his shoulder injury and would estimate 25° ppi to the left upper extremity. I told Jack he should try to find work he could perform with limited use of his left arm and no working above shoulder level. He may return as needed.

s/ Phillip D. Lawhorn, M.D.

Phillip D. Lawhorn, M. D.

JOB DESCRIPTION
CARPENTER
(with maximum physical requirements)

Carpenter uses hand tools to build forms, scaffolds, partitions, and other wood structures.

Pushing/Pulling	1 hour per day
Sitting	3 hours per day
Walking	3 hours per day
Lifting	3 hours per day*
Bending	1 hour per day
Squatting	1 hour per day
Climbing	1 hour per day
Kneeling	1 hour per day
Standing	3 hours per day
Working Above Shoulder	1 hour per day

* Lifting 0 -20 lbs = 2 hours per day
* Lifting 20 - 50 lbs = 1 hour per day
* Lifting 50 - 100 lbs = 1 time per day

Position requires ability to grasp with both hands and a general good dexterity in both hands.

TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

a. Given the work limitations specified, is he able to perform his regular job? Check the best answer below.

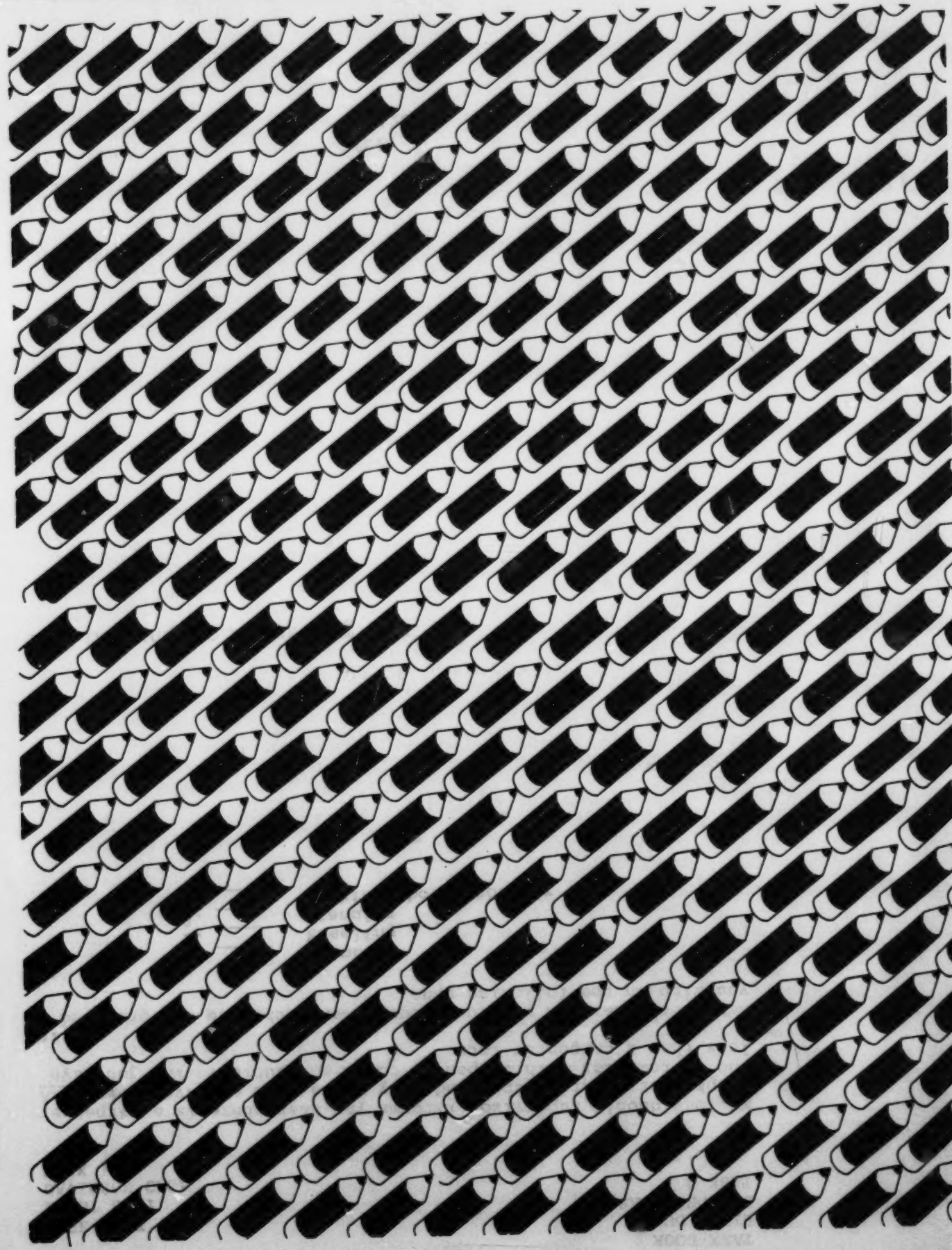
Yes ____ No ____

b. If your answer is no, circle the number next to any of his duties listed below that conflict with the stated work limitations.

1. _____ Climbing
2. _____ Kneeling
3. _____ Standing
4. _____ Working Above Shoulder

TURN TO PAGE 120 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
DAVIDSON CASE
TASK 1

Answer:

a. No

b.

1. _____ Climbing
2. _____ Kneeling
3. _____ Standing
4. __X__ Working Above Shoulder

TURN THE PAGE AND DO THE NEXT TASK.

Mr. Davidson's supervisor informs you that there is a carpenter shopkeeper position open and they would like to have someone who is familiar with carpentry tools and duties. The job pays less than a carpenter rate.

Review the maximum physical requirements that he has provided you with on the following page.

JOB DESCRIPTION
CARPENTER SHOPKEEPER
(with maximum physical requirements)

Carpenter Shopkeeper is responsible for keeping all carpenter's hand tools in order and maintaining proper inventory records for the tools. Sends damaged tools out for repair or replacement.

Pushing/Pulling	1/2 hour per day
Sitting	5 hours per day
Walking	3 hours per day
Lifting	2 hours per day*
Bending	1/2 hour per day
Squatting	1 hour per day
Climbing	0 hours per day
Kneeling	1 hour per day
Standing	4 hours per day
Working Above Shoulder	0 hours per day

* Lifting 0 -20 lbs = 2 hours per day
* Lifting 20 - 50 lbs = 2 times per day
* Lifting 50 - 100 lbs = 0 times per day

Position requires ability to recognize carpenter's tools and tools required for specific carpenter's duties.

TURN THE PAGE.

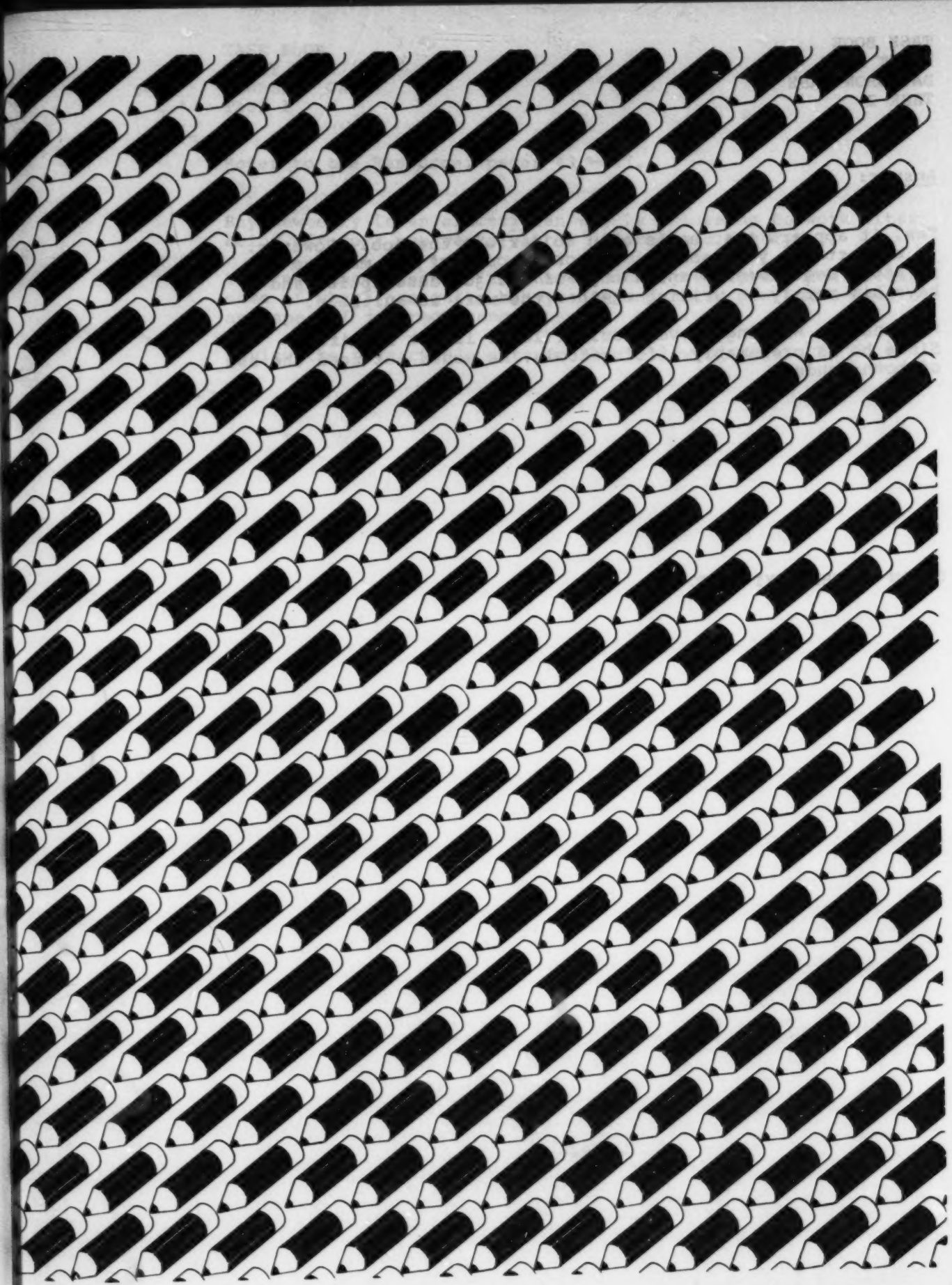
a. Does it appear that Mr. Davidson can perform these duties?

Yes ____ No ____

b. Briefly give your rationale.

AFTER YOU HAVE RECORDED YOUR ANSWERS, TURN TO PAGE 124 AND COMPARE YOURS WITH THE BOOK ANSWERS.

END OF TASK MATERIAL



Answer:

Yes, it appears that he is able to perform the job. However, to be certain, you send Dr. Lawhorn a copy of the maximum physical requirements and a copy of the job description and have him verify in writing whether the work is suitable.

Rationale: Working above shoulder level is not required. Since he is presumably lifting tools, he would not need the use of both hands.

GO ON TO THE NEXT CASE.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

Refer to the Resource, pages 43 - 47.

Ray Newberry is an electrician who is returning to work after being off work two weeks with a job-related injury.

You know that electricians have to carry equipment and tools, some of which are quite heavy. Beyond that, you don't know of any special job requirements.

Review the physician's note on the following page.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

March 30, 1984

RE: Ray Newberry

Patient may return to work. He should avoid continuous, heavy lifting and should limit pushing and pulling for 2 weeks.

-s/ Don Thompson MD

Don Thompson, M. D.

TURN THE PAGE.

TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

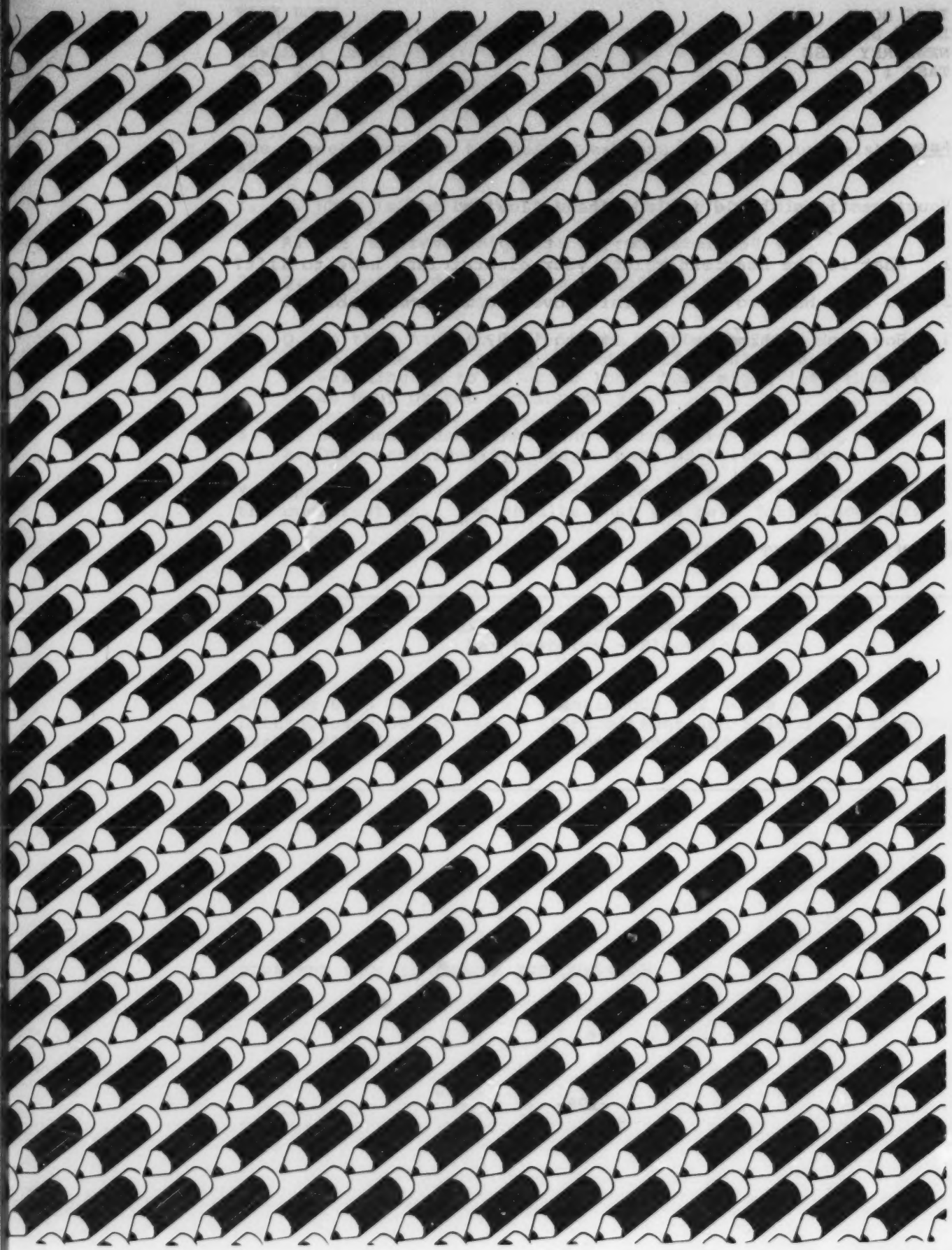
You call Mr. Newberry's supervisor and report the constraints listed in Dr. Thompson's note and ask the supervisor if suitable work is available. Mr. Newberry's supervisor has a reputation for not accepting employees who are limited/restricted. He informs you that he cannot work Mr. Newberry until he is able to perform his regular duties.

TASK:

What 3 questions would you ask of the supervisor to clarify whether the medical constraints conflict with his regular job duties? (The CA-17 defines heavy lifting as lifting from 50 to 100 pounds.) Write your answers below.

AFTER YOU HAVE WRITTEN YOUR ANSWERS, TURN TO PAGE 128 AND READ THE BOOK ANSWERS.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 1

Answer:

Your questions should include the following:

1. What is the heaviest weight your electricians have to lift?
2. Do they have to lift anything over 50 lbs continuously?
3. How much pushing/pulling is required?

GO ON TO THE NEXT TASK.

The answers you get to these questions from the supervisor are as follows:

1. Q. What is the heaviest weight your electricians have to lift?
   A. The heaviest weight is approximately 50 lbs.

2. Q. How often do they have to lift 50 lbs?
   A. Only once a day.

3. Q. Do they have to lift 50 lbs continuously?
   A. No. The only thing lifted continuously are hand tools weighing up to 15 or 20 lbs. They might lift those for an hour or two continuously.

4. Q. How much pushing/pulling is required?
   A. Only occasionally - maybe once or twice a day.

You and the supervisor informally record these answers during the conversation. The results that you have jotted down are:

Maximum Physical Requirements
Ray Newberry - Electrician

Lifting 0-20 lbs.	Continuous - 2 hours a day
Lifting over 50 lbs	Intermittent and Seldom - 1 time/day
Pushing/Pulling	Intermittent and Seldom - 1 time/day

TURN THE PAGE TO ANSWER THE QUESTION.

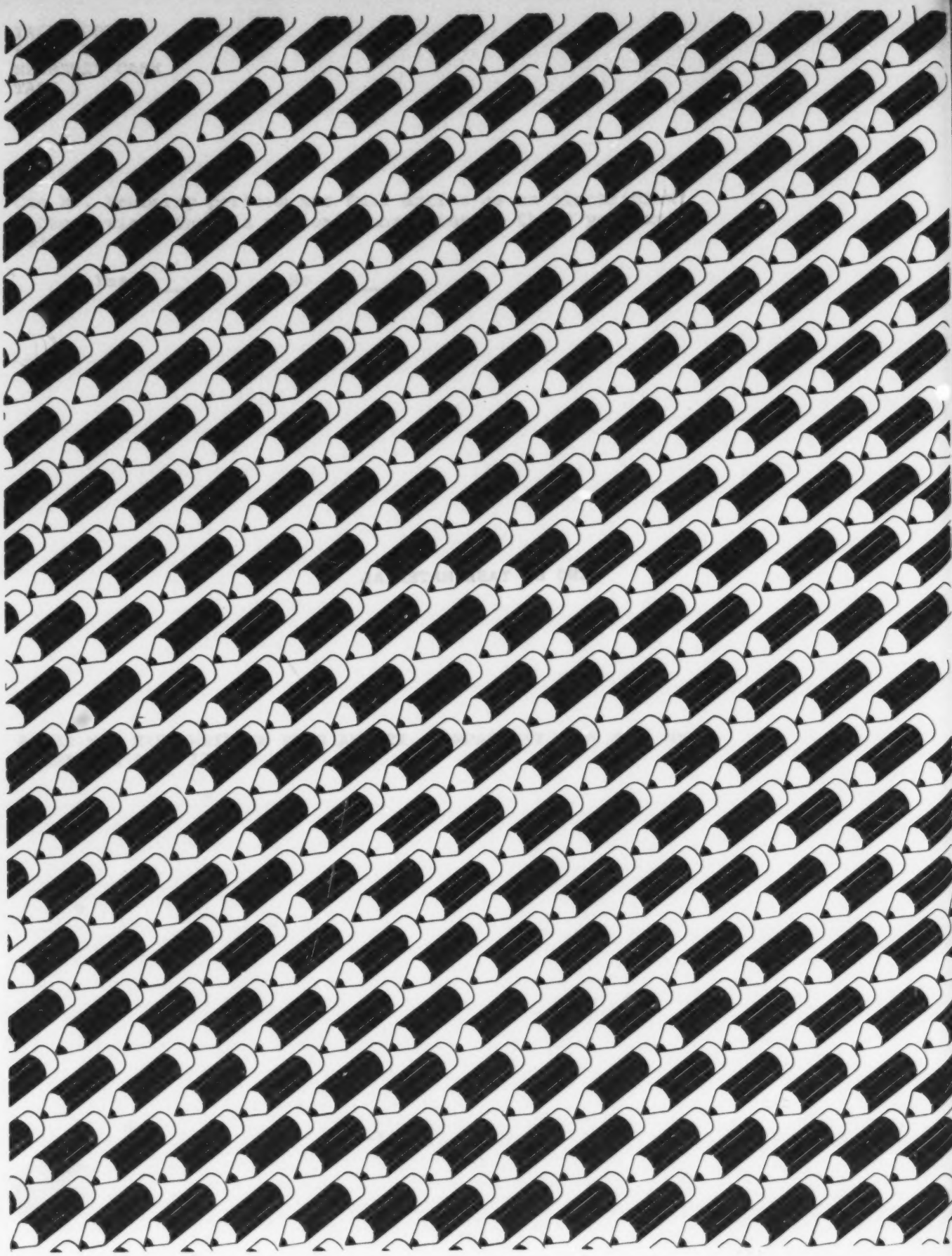
TASK BOOK
LIGHT DUTY
NEWBERRY CASE
TASK 2

Can Mr. Newberry perform his full duties as an electrician without violating his medical constraints? Check your answer below.

Yes ____ No ____

AFTER YOU HAVE WRITTEN YOUR ANSWER, COMPARE IT WITH THE BOOK ANSWER ON PAGE 131.

END OF TASK MATERIAL



Answer:

Yes. Regular duties will not require that he do any continuous heavy lifting - he would lift heavy weight only intermittently once a day. Also, regular work will not require him to push or pull more than once a day.

TURN THE PAGE AND DO THE NEXT CASE.

TASKBOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

On the following pages (133 - 139) review the CA-1 for Joseph Saunders, Dr. Right's CA-17 dated 1/13/84, and the light duty job descriptions.

Select the light duty assignment that best meets the work limitations for Joseph Saunders. Then go to the worksheet on page 140.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☒ Male ☐ Female	4. Social Security Number
Saunders, Joseph A.	3/21/49		012-64-3011

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
704 E. Spencer St. Baltimore Md. 21231	Area Code: 301 Number: 434-7052

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U.S. Postal Service 900 E. Fayette Street Baltimore, Md. 21233-9408	in front of 354 Velmont Street.

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
1-3-84 9:00 ☐ AM ☒ PM	1-3-84	Wife/Husband ☒ Children Under 18 Years Old ☒	Lettercarrier

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Fell on icy pavement and hurt my back	injured lower back in fall

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☒ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Joseph A. Saunders
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
U.S. Postal Service

22. Bureau or Office
Baltimore

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
U.S. Postal Service 900 E. Fayette St., Bald. Md. 212339408

24. Regular Work Day
Begins 730 ☒ AM ☐ PM
Ends 4:00 ☐ AM ☒ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) T (W) T (F) S

27. Date and Hour of Injury *(mo., day, year)*
1-3-84 ☐ AM
3:00 ☒ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
1-3-84

29. Date and Hour Stopped Work *(mo., day, year)*
1-3-84 3:00 pm

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
N/A

31. 45 Day Period Begins *(mo., day, year)*
1-4-84

32. Pay Rate When Employee Stopped Work
$22402 per yr

33. Date and Hour Employee Returned to Work *(mo., day, year)*
☐ AM
☐ PM

34. Name of Supervisor At Time of Injury
Thomas Wilson

35. Was Employee In Performance of Duty At The Time of Injury? ☒ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
1-3-84

39. Name and Address of Physician First Providing Medical Care
Louis S. Right M.D.
1313 St Paul Place
Baltimore, MD. 21230

40. Do Medical Reports Show Employee Is Disabled For Work?
☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☒ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Thomas S. Wilson

44. Title and Office Phone Number
Supervisor 254-9674

45. Date *(mo., day, year)*
1-3-84

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Louis S Right, M.D.
1313 St Paul Place
Balto, MD 21230

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Saunders, Joseph A	1/3/84	Letter Carrier	012-64-3011

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Fell on icy pavement, injured low back

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD 5 hours - NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			5 hours
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS	none		
PULLING/PUSHING, CARRYING			5 hours
REACHING OR WORKING ABOVE SHOULDER			3 hours
WALKING (HOURS)			5 hours
STANDING (HOURS)			3 hours
SITTING (HOURS)	none		
STOOPING (HOURS)	little		
KNEELING (HOURS)	none		
REPEATED BENDING (HOURS)	little		
CLIMBING (HOURS)	1 hour		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	none		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S Postal Service
900 E Fayette Street
Balto Md 21233-9408

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☑ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS	✓		
LIGHT – LIFTING 10 to 20 POUNDS	✓		
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING	✓		
REACHING OR WORKING ABOVE SHOULDER	✓		
WALKING (1 HOURS)		✓	
STANDING (1 HOURS)		✓	
SITTING (8 HOURS)			✓
STOOPING (0 HOURS)	✓		
KNEELING (0 HOURS)	✓		
REPEATED BENDING (0 HOURS)	✓		
CLIMBING (0 HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			✓
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 1/3/84 TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☑ 1/3/84
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*
1/3/84

16. DIAGNOSIS OF CONDITION DUE TO INJURY
lumbo sacral strain

17. DATE OF EXAMINATION 1/3/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY 1/17/84

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Louis S. Right, M.D

20. PROFESSIONAL DEGREE
M.D

21. DATE *(Mo., day, year)*
1/3/84

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TASKBOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

JOB DESCRIPTION

Office Clerk

Physical Requirements: Ability to use both hands. No lifting, bend stopping, climbing, reaching above shoulders required. Ability to do limited walking/standing preferred but not required.

Environmental Factors: Office work. Sedentary using a swivel chair with arm and backrests. Elevation of limbs as well as canes and crutches permissible.

Proficiency: General office work. Handwriting and alphabetizing skills preferred. Some use of office equipment such as xerox machines.

Schedule: Off days: Saturday/Sunday
Reporting time: 6:00 a.m. to 8:30 a.m. on the half hour

Available Assignments:

Zip Code Unit	Rm 512	6:00 a.m.
Centralized Forms	Rm 407	6:30 a.m.
Medical Unit	Rm 326	7:00 a.m.
Personnel	Rm 509	7:30 a.m.
Certification/Testing	Rm 302	8:00 a.m.
Claims and Tracers	Rm 517	8:30 a.m.

TASKBOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

JOB DESCRIPTION

Mark-Up Clerk

Physical Requirements: Ability to lift 10 pounds. Chiefly sedentary work with the ability to do limited walking, standing, bending and twisting. No squatting, climbing or kneeling. No work above shoulder level. Must have one good arm preferably the one they write with.

Environmental Factors: Factory environment. Sitting in a chairback drafting stool with no armrests. Elevation of limbs, canes, crutches, and open toed shoes not allowed.

Proficiency: Mark up address corrections and manually file the corrected mail. Handwriting and ability to file mail by zip code required.

Schedule: Off days: 2 days to be negotiated; this is a 7 day-a-week operation

Reporting Time: 24 hour a day operation - hours to be negotiated

Assignment: Centralized Mark-Up Unit, Room 208

JOB DESCRIPTION

File Clerk

Physical Requirements: Ability to lift 25 pounds. Primarily standing work with ability to do limited sitting. Bending, twisting, and reaching above shoulders required. No squatting, climbing or kneeling. Must have one good arm.

Environmental Factors: Factory environment. Standing and filing mail with the ability to do limited sitting on a stool. No arm or backrest available. Elevation of limbs, canes, crutches, and open-toed shoes not allowed.

Proficiency: Ability to file mail by zip code.

Schedule: 24 hour a day, 7 day a week operation. Two off-days to be negotiated.

Assignment: Main Post Office, second floor, operation 430.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 1

On the choices below, circle the letter in front of the job that best meets Mr. Saunders' work limitations. Then turn to the page indicated next to your choice.

a. Office clerk. Turn to page 161, Box 4.

b. Mark-up clerk. Turn to page 142, Box 1.

c. File clerk. Turn to page 141, Box 2.

From page 105

1

Correct. The file is missing (d) - a response from the employee's supervisor indicating if there are any other expenses that the employee incurred. You cannot figure the lien without this response.

Turn to page 108 to continue the case.

From page 140

2

No. The file clerk position has physical requirements that exceed work limitations of:

1) lifting 25 lbs
2) bending
3) reaching above shoulder

Return to page 140 and try again.

From page 96

3

Although the claimant did not claim third party liability, this does not <u>determine</u> liability. You still need evidence.

Return to page 96 and try again.

From page 97

4

No. It is possible that there were witnesses, and that you could find them to interview, but this would mean a time consuming investigation. There is a better way.

Return to page 97 and make another selection.

From page 140

1

No. The position of mark-up clerk (choice b.) has physical requirements that exceed his work limitations:

- ability to lift 10 lbs.
- bending
- limited walking and standing may possibly exceed his work limitations.

Return to page 140 and try again.

From page 78

2

No, you would not terminate COP because fact of injury is not grounds for terminating COP.

Turn to page 81 for the next case.

From page 96

3

No. There is no evidence of faulty equipment.

Return to page 96 for another try.

From page 105

4

No. This is in the file.

Return to page 105 for another try.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 2

a. Of the available office clerk assignments which should Mr. Saunders be given? Circle the letter of your choice. Then answer question b. below before turning to the page indicated.

1. Zip Code Unit	Rm 512	6:00 a.m.	Turn to page 168, Box 4.
2. Centralized Forms	Rm 407	6:30 a.m.	Turn to page 167, Box 2.
3. Medical Unit	Rm 326	7:00 a.m.	Turn to page 169, Box 1.
4. Personnel	Rm 509	7:30 a.m.	Turn to page 161, Box 1.

b. Briefly state below why you chose the answer you did.

TASK BOOK
LIGHT DUTY
SAUNDERS CASE
TASK 3

Mr. Saunders returned to his treating physician, Louis S. Right, M.D. on 1/17/84 for a follow-up appointment. Review the attached CA-17 dated 1/17/84 and determine if Mr. Saunders is still in the limited duty assignment which best meets his physical restrictions.

If not, use the position descriptions provided in TASK 1 (pages 137 - 139) and think about whether you would reassign him to one of these positions or keep him in the office clerk job.

After reviewing the position descriptions, go to the worksheet on page 147 and answer the questions.

OMB No. 1215-0103 —Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
Louis S. Rigle, M.D.
1313 St Paul Place
Balto Md 21230

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Saunders, Joseph A	1/3/84	letter Carrier	012-64-3011

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
Fell on icy pavement, injured low back

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD 5 hours NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK — Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			5 hours
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS	none		
PULLING/PUSHING, CARRYING			5 hours
REACHING OR WORKING ABOVE SHOULDER			3 "
WALKING (HOURS)			5 "
STANDING (HOURS)			3 "
SITTING (HOURS)	none		
STOOPING (HOURS)	little		
KNEELING (HOURS)	none		
REPEATED BENDING (HOURS)	little		
CLIMBING (HOURS)	1 hour		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	none		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
U.S.P.S.
900 E Fayette St
Balto Md 21233-9408

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☑ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER		✓	
WALKING (4 HOURS)		✓	
STANDING (4 HOURS)		✓	
SITTING (4 HOURS)		✓	
STOOPING (1 HOURS)		✓	
KNEELING (1 HOURS)		✓	
REPEATED BENDING (1 HOURS)		✓	
CLIMBING (0 HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			✓
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(if termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 1/17/84 TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☑ 1/17/84
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*
1/31/84

16. DIAGNOSIS OF CONDITION DUE TO INJURY
resolving lumbosacral strain

17. DATE OF EXAMINATION 1/17/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY 2/17/84

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Louis S Right

20. PROFESSIONAL DEGREE
m.D

21. DATE *(Mo., day, year)*
1/17/84

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Mr. Saunders has shown some improvement. Circle the letter in front of the decision you would make at this point regarding Mr. Saunders' job.

a. Keep him in the office clerk job. Turn to page 167, Box 1.

b. Reassign him to the mark-up clerk job. Turn to page 161, Box 3.

c. Reassign him to the file clerk job. Turn to page 168, Box 2.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Review the CA-17 for James Ryan and the job description for Welder, WG-3703-10 on the following three pages. Then do the task on page 152.

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Shipyard Dispensary, Norfolk, VA.

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Ryan, James Robert	3/18/83	Welder	349-80-1763

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Fell while climbing vertical ladder on board the America

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD _____ NOISE 4-6 hrs DUST 4-6 hrs

FUMES 6 hrs STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS		✓	
LIGHT – LIFTING 10 to 20 POUNDS		✓	
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER		✓	
WALKING (HOURS)		✓	
STANDING (HOURS)		✓	
SITTING (HOURS)		✓	
STOOPING (HOURS)			✓
KNEELING (HOURS)			✓
REPEATED BENDING (HOURS)			✓
CLIMBING (HOURS)			✓
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

Naval Shipyard
Norfolk, VA.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☑ FULL TIME *Date (Mo., day, year)* light duty only in Consonance with restrictions, in two weeks

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS		✓	
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER		✓	
WALKING (HOURS)		✓	
STANDING (HOURS)		✓	
SITTING (HOURS)			✓
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.		✓	
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS
Out of work for 2 weeks
Light duty after that

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM Present TO 2 April
PARTIAL DISABILITY FROM 3 April TO Indefinite

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☑
REGULAR WORK ☐ in two weeks

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OR CONDITION DUE TO INJURY Mr. Rezon has sustained a disabling injury to his knee as a result of a fall he sustained on the USS AMERICA. The fall resulted in torn ligaments and his kneecap was virtually crushed in the fall

17. DATE OF EXAMINATION 3/9/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY 4/19/83

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
James M Wright

20. PROFESSIONAL DEGREE
M.D

21. DATE *(Mo., day, year)*
3/20/83

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TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

JOB DESCRIPTION
Welder, WG-3703-10

Performs all types of welding on all types of surfaces, such as deck plates, ship's hull, fitting, etc. Is knowledgeable of all welding processes, e.g., MIG, TIG. Is able to perform work with normal supervision.

Assists and instructs helpers and apprentices in the trade.

Incumbent is required to work in all types of environment, and is exposed to heat, noise and cold on board ships and subs. Must be able to weld in any and all types of positions, i.e., kneeling, stooping, bending. May be required to lift up to 30 lbs. Climbs on board ships and subs.

Incumbent will be required to recertify his or her qualifications at two year intervals in the various types of welding processes.

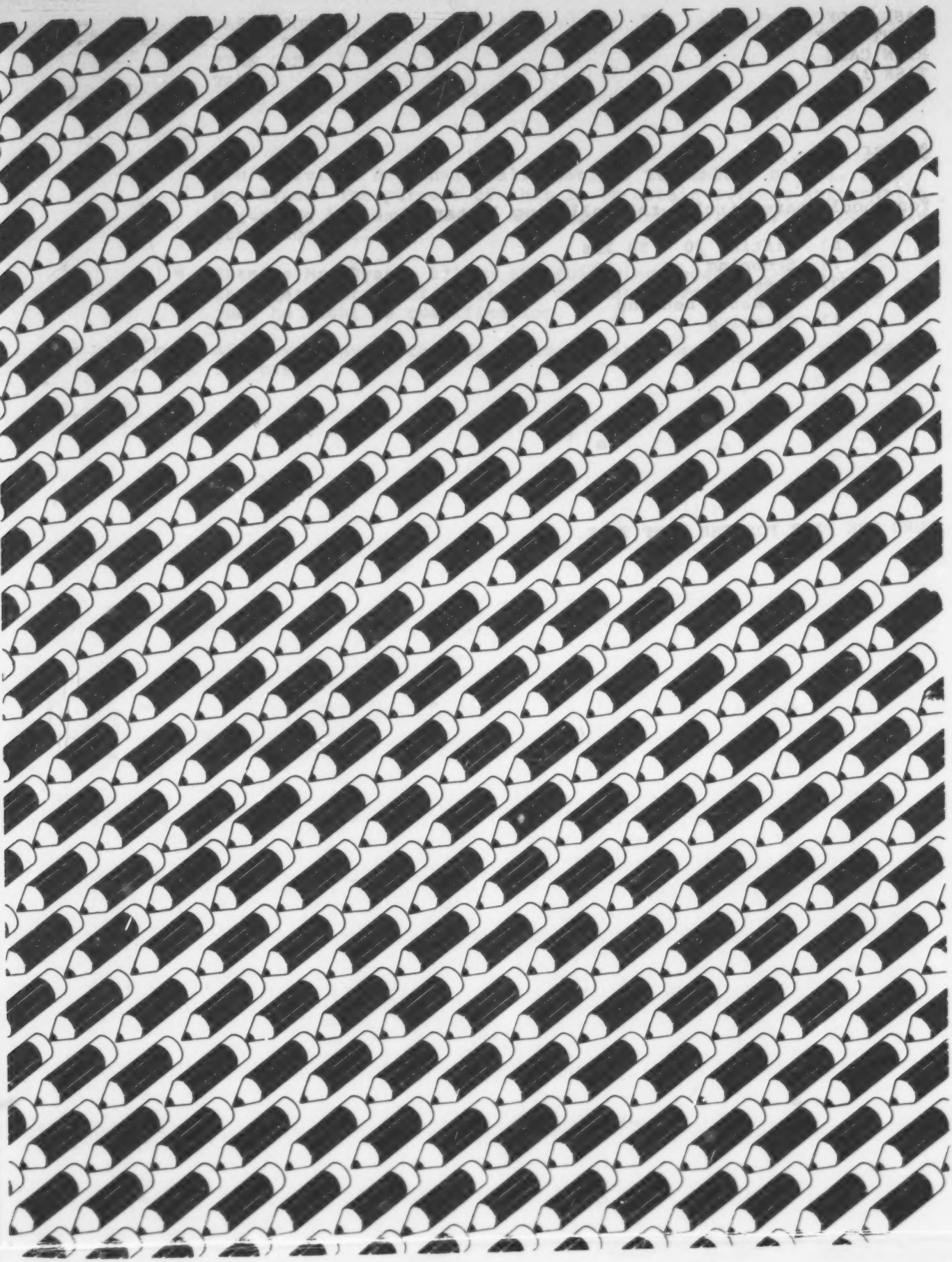
TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Circle below the letters of those physical job requirements enumerated in the job description on page 151 that conflict with Mr. Ryan's work limitations.

a) Light lifting - 10 to 20 pounds
b) Moderate lifting - 20 to 50 pounds
c) Heavy lifting - 50 to 100 pounds
d) Pulling, pushing, carrying
e) Reaching or working above shoulder
f) Walking
g) Standing
h) Sitting
i) Stooping
j) Kneeling
k) Repeated bending
l) Climbing
m) Operating a motor vehicle, crane, tractor, etc.

WHEN YOU HAVE COMPLETED THE TASK, TURN TO PAGE 153 AND COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 1

Answer:

You should have circled the following letters:

b) Lifting 20 - 50 lbs
i) Stooping
j) Kneeling
k) Repeated bending
l) Climbing

TURN THE PAGE FOR THE NEXT TASK.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 2

You solicit a Personal Qualifications Statement, SF-171, from Mr. Ryan. The purpose of this is to obtain current information regarding his experience, education, and training, for possible job placement.

Examine Mr. Ryan's 171 on the following pages. Assume that each description of duties is complete. Focus on the types of jobs he might be qualified for.

After you review the 171 go to the worksheet on page 160 and do the task.

Personal Qualifications Statement

Read instructions before completing form

Form Approved:
OMB No. 3206-0012

1. Kind of position *(job)* you are filing for *(or title and number of announcement)*

2. Options for which you wish to be considered *(if listed in the announcement)*

3. Home phone — Area Code: 405 | Number: 9217

4. Work phone — Area Code: 387 | Number: 7154 | Extension: —

5. Sex *(for statistics only)* — ☑ Male ☐ Female

6. Other last names ever used

Name *(Last, First, Middle)*: Ryan, James R.

Street address or RFD no. *(include apartment no., if any)*: 58 Carpenter St.

City: Chesapeake | State: Va. | ZIP Code: 23321

8. Birthplace *(City & State, or foreign country)*: Jacksonville Fla.

9. Birth date *(Month, day, year)*: 4 | 19 | 48

10. Social Security Number: 349-80-1763

11. If you have ever been employed by the Federal Government as a civilian, give your highest grade, classification series, and job title.

Welder - WG-10

Dates of service in highest grade *(Month, day, and year)*

From: 8 | 1978 To: Present

12. If you currently have an application on file with the Office of Personnel Management for appointment to a Federal position, list: (a) the name of the area office maintaining your application, (b) the position for which you filed, and *(if appropriate)* (c) the date of your notice of rating, (d) your identification number, and (e) your rating.

—

13. Lowest pay or grade you will accept

PAY		GRADE
$ per	OR	WG-10

14. When will you be available for work? *(Month, and year)*: Now

15. Are you available for temporary employment lasting:

(Acceptance or refusal of temporary employment will not affect your consideration for other appointments.)

	YES	NO
A. Less than 1 month?		
B. 1 to 4 months?		
C. 5 to 12 months?		

16. Are you interested in being considered for employment by:

	YES	NO
A. State and local government agencies?		
B. Congressional and other public offices?		
C. Public international organizations?		

17. Where will you accept a job?

	YES	NO
A. In the Washington, D.C. Metropolitan area?		
B. Outside the 50 United States?		
C. Anyplace in the United States?		
D. Only in *(specify locality)*		

18. Indicate your availability for overnight travel:

- ☐ A. Not available for overnight travel
- ☐ B. 1 to 5 nights per month
- ☐ C. 6 to 10 nights per month
- ☐ D. 11 or more nights per month

19. Are you available for part-time positions *(fewer than 40 hours per week)* offering:

	YES	NO
A. 20 or fewer hours per week?		
B. 21 to 31 hours per week?		
C. 32 to 39 hours per week?		

20. Veteran Preference. Answer all parts. If a part does not apply to you, answer "NO"

	YES	NO
A. Have you ever served on active duty in the United States military service? *(Exclude tours of active duty for training in Reserves or National Guard)*		
B. Have you ever been discharged from the armed services under other than honorable conditions? *You may omit any such discharge changed to honorable or general by a Discharge Review Board or similar authority)*. If "YES", give details in item 34.		
C. Do you claim 5-point preference based on active duty in the armed forces? If "YES", you will be required to furnish records to support your claim at the time you are appointed.		
D. Do you claim 10-point preference? If "YES," check the type of preference claimed and complete and attach Standard Form 15, "Claim for 10-Point Veteran Preference," together with the proof requested in that form.		

Type of Preference: ☐ Compensable Disability 30% or More ☐ Compensable Disability Below 30% ☐ Non-compensable Disability ☐ Purple Heart Recipient ☐ Spouse ☐ Widow(er) ☐ Mother

E. List dates, branch, and serial number of all active service *(enter "N/A", if not applicable)*

From	To	Branch of Service	Serial or Service Number
Apr '70	Apr 74	U.S. Navy	A-196843

DO NOT WRITE IN THIS BLOCK

FOR USE OF EXAMINING OFFICE ONLY

Material: ☐ Submitted ☐ Returned

Entered register:

Notations:

Form reviewed:

Form approved:

ANNOUNCEMENT NO.

STATEMENT NO.

Option	Grade	Earned Rating	Preference	Aug. Rating
			☐ 5 Points (Tent.)	
			☐ 10 Pts. 30% or More Comp. Dis.	
			☐ 10 Pts. Less Than 30% Comp. Dis.	
			☐ Other 10 Points	
			☐ Disallowed	
Initials and date			☐ Being Investigated	

THIS SPACE FOR USE OF APPOINTING OFFICER ONLY

Preference has been verified through proof that the separation was under honorable conditions, and other proof as required

☐ 5-Point ☐ 10 Points 30% or More Compensable Disability ☐ 10 Points Less Than 30% Compensable Disability ☐ 10-Point Other

Signature and title

Agency | Date

THE FEDERAL GOVERNMENT IS AN EQUAL OPPORTUNITY EMPLOYER

21 Experience. Begin with current or most recent job or volunteer experience and work back. Account for periods of unemployment exceeding three months and your residence address at that time on the last line of the experience blocks in order of occurrence.

May inquiry be made of your present employer regarding your character, qualifications, and record of employment? (A "NO" will not affect your consideration for employment opportunities except for Administrative Law Judge positions.) ☐ YES ☐ NO

A

Name and address of employer's organization (include ZIP code, if known)
Norfolk Shipyard
Norfolk, Va.

Dates employed (give month and year): From 6/74 To Present
Average number of hours per week: 40
Salary or earnings: Beginning $ 5.60 per hr. Ending $ 10.50 per hr.
Place of employment: City Norfolk State Va

Exact title of your position: Welder
Name of immediate supervisor: Roberts
Area Code Telephone number: 397 4974
Number and kind of employees you supervise: —
Kind of business or organization (manufacturing, accounting, social services, etc.):
If Federal service, civilian or military, series, grade or rank, and date of last promotion: W6-10
Your reason for wanting to leave:

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)
Served Welder apprenticeship from June of [redacted] 1974 to June 1978. Have been journeyman Welder since 1978.

For agency use (skill codes, etc.):

B

Name and address of employer's organization (include ZIP code, if known)
U.S. NAVY

Dates employed (give month and year): From 4/70 To 4/74
Average number of hours per week: 40
Salary or earnings: Beginning $ per Ending $ per
Place of employment: City Pensacola State Fla

Exact title of your position: YEOMAN E-4
Name of immediate supervisor: Chief Brooks
Area Code Telephone number: 712 [illegible]-8492
Number and kind of employees you supervised: —
Kind of business or organization (manufacturing, accounting, social services, etc.): Govt.
If Federal service, civilian or military, series, grade or rank, and date of last promotion: E-4 1/74
Your reason for leaving: Honorably Discharged

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)
Worked in the Military Personnel Office at Naval Station, Pensacola. Typed up orders, discharges and fitness reports, sorted mail, answered general inquiries regarding military pay and records. Filed material in appropriate service jackets. See attached

For agency use (skill codes, etc.):

C

Name and address of employer's organization (include ZIP code, if known)
Newport News Shipbuilding & Drydock
Newport News, Va

Dates employed (give month and year): From 9/66 To 11/69
Average number of hours per week: 40
Salary or earnings: Beginning $ 2.85 per hr. Ending $ 4.10 per hr.
Place of employment: City Newport News State Va

Exact title of your position: Helper
Name of immediate supervisor: Dick Davis
Area Code Telephone number: 804 [illegible]-1248
Number and kind of employees you supervised: —
Kind of business or organization (manufacturing, accounting, social services, etc.): Private Shipyard
If Federal service, civilian or military, series, grade or rank, and date of last promotion: —
Your reason for leaving: Military

Description of work (Describe your specific duties, responsibilities, and accomplishments in this job)
Served as a helper to a Welder mechanic.

For agency use (skill codes, etc.):

If you need additional experience blocks, use Standard Form 171-A or blank sheets of paper

SEE INSTRUCTION SHEET

Attach Supplemental Sheets or Forms Here

22. A. Special qualifications and skills (skills with machines; patents or inventions; your most important publications [do not submit copies unless requested]; your public speaking and publications experience; membership in professional or scientific societies, etc.)

B. Kind of license or certificate (pilot, registered nurse, lawyer, radio operator, CPA, etc.)	C. Latest license or certificate: Year	State or other licensing authority	D. Approximate number of words per minute: Typing	Shorthand
			41 wpm	—

23. A. Did you graduate from high school or will you graduate within the next nine months, or do you have a GED high school equivalency certificate?

Yes	Month and Year	No	Highest grade completed
✓	6/66		

B. Name and location (city and State) of latest high school attended: Wilkes High School, Va. Beach, Va.

C. Name and location (city, State, and ZIP Code, if known) of college or university. (If you expect to graduate within nine months, give MONTH and YEAR you expect to receive your degree.)

	Dates Attended: From	To	Years Completed: Day	Night	No. of Credits Completed: Semester Hours	Quarter Hours	Type of Degree (e.g., B.A.)	Year of Degree
Tidewater Community College	6/66	9/66				3		

D. Chief undergraduate college subjects	No. of Credits Completed: Semester Hours	Quarter Hours	E. Chief graduate college subjects	No. of Credits Completed: Semester Hours	Quarter Hours
Data Processing		3			

F. Major field of study at highest level of college work

G. Other schools or training (for example, trade, vocational, Armed Forces or business). Give for each the name and location (city, State and ZIP Code, if known) of school, dates attended, subjects studied, number of classroom hours of instruction per week, certificate, and any other pertinent data.

1970 - Basic Typing I - 160 classroom hours
1971 - Correspondence Procedures - 40 hours
- Clerical training - 90 classroom hours
Basic Drafting - 40 classroom hours

24 Honors, awards, and fellowships received: Honor Graduate, Apprentice School

25 Languages other than English. List the languages (other than English) in which you are proficient and indicate your level of proficiency by putting a check mark (✓) in the appropriate columns. Candidates for positions requiring conversational ability in a language other than English may be given an interview conducted solely in that language. Describe in item 34 how you gained your language skills and the amount of experience you have had (e.g., completed 72 hours of classroom training, spoke language at home for 18 years, self-taught, etc.).

Name of Language(s)	PROFICIENCY: Can Prepare and Deliver Lectures: Fluently	With Difficulty	Can Converse: Fluently	Passably	Have Facility to Translate Articles, Technical Materials, etc: Into English	From English	Can Read Articles, Technical Materials, etc., for Own Use: Easily	With Difficulty

26 References. List three persons who are NOT related to you and who have definite knowledge of your qualifications and fitness for the position for which you are applying. Do not repeat names of supervisors listed under Item 21, Experience.

Full Name	Present Business or Home Address (Number, Street, City, State and ZIP Code)	Telephone Number (Include Area Code)	Business or Occupation
Chadwick, E.D.C.	312 Burr Oak, Va. Beach	—	Welder
Martin, Donald	18 Carrier Court, Ches	—	Foreman
Edwards, Earl	21 Crestwood Dr. Ches	—	Planner

Continuation Sheet
Item 21B

While in the U. S. Navy from 1970 to 1974, I served as a yeoman in the Military Personnel Office. I was responsible for typing up travel and transfer orders for military personnel.

I filed correspondence in appropriate service jackets and subject matter files. I routed all incoming mail within the office. I prepared memoranda and letters using appropriate naval correspondence procedures.

I typed up fitness reports and discharge notices. I typed most of the correspondence emanating from that office. I was responsible for proper format and punctuation.

I set up a new file system, and a tickler system on all pertinent correspondence and reports. I compiled figures for various reports and checked them for accuracy.

Answer items 27 through 33 by placing an X in the proper column	YES	NO
27 Are you a citizen of the United States? If NO, give country of which you are a citizen		
NOTE: A conviction of a crime does not necessarily mean you cannot be appointed. The circumstances of the occurrence(s) and how long ago it (they) occurred are important. Give all the facts so that a decision can be made. 28 Within the last five years have you been fired from any job for any reason?		
29 Within the last five years have you quit a job after being notified that you would be fired? If your answer to 28 or 29 above is YES, give details in item 34. Show the name and address (*including ZIP Code*) of employer, approximate date, and reasons in each case. This information should agree with your answers in item 21, Experience.		
30 A Have you **ever** been convicted, forfeited collateral, or are you now under charges for **any felony** or **any** firearms or explosives offense against the law? *A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified under the laws of a State as a misdemeanor which is punishable by a term of imprisonment of two years or less.*		
B During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in A above?		
NOTE: When answering A and B above, you may omit: (1) traffic fines for which you paid a fine of $50.00 or less, (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law, (3) any conviction the record of which has been expunged under Federal or State law, and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.		
31 While in the military service were you ever convicted by a general court-martial? If your answer to 30A, 30B, or 31 is YES, give details in item 34. Show for each offense: (1) date, (2) charge, (3) place, (4) court, and (5) action taken.		
32 Does the United States Government employ in a civilian capacity or as a member of the Armed Forces any relative of yours (*by blood or marriage*)? (*See item 32 in the attached instruction sheet.*) If your answer to 32 is YES, give in item 34 for such relatives: (1) name, (2) present address (*including ZIP Code*), (3) relationship, (4) department, agency, or branch of the armed forces.		
33 Do you receive, or do you have pending application for, retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia Government service? If your answer to 33 is YES, give details in item 34. If military retired pay, include the rank at which you retired.		

Your Statement cannot be processed until you have answered all questions, including items 27 through 33, above. Be sure you have placed an X to the left of EVERY marker (◀) above, either in the YES or NO column.

34 Item No.	Space for detailed answers. Indicate item numbers to which the answers apply.

If more space is required, use full sheets of paper approximately the same size as this page. Write on each sheet your name, birth date, and announcement or position title. Attach all sheets to this Statement at the top of page 3.

ATTENTION—THIS STATEMENT MUST BE SIGNED

Read the following paragraphs carefully before signing this Statement

A false answer to any question in this Statement may be grounds for not employing you, or for dismissing you after you begin work, and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001). All the information you give will be considered in reviewing your Statement.

AUTHORITY FOR RELEASE OF INFORMATION

I have completed this Statement with the knowledge and understanding that any or all items contained herein may be subject to investigation prescribed by law or Presidential directive and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, Personnel Staffing Specialists, and other authorized employees of the Federal Government for that purpose.

CERTIFICATION

I certify that all of the statements made by me are true, complete and correct to the best of my knowledge and belief, and are made in good faith.

SIGNATURE (*sign in ink*) James L. Ryan

DATE 3/29/83

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 381-526 (8303)

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 2

Assuming that all of the following jobs are in accord with the work limitations, which of the following types of jobs is Mr. Ryan qualified for? Circle the letter in front of your choice(s), then turn to the page listed next to your answer.

a. Personnel Specialist only. Turn to page 168, Box 3.

b. Clerk Typist only. Turn to page 167, Box 4.

c. Drafting (e.g. engineering technician) only. Turn to page 169, Box 3.

d. File Clerk. Turn to page 161, Box 2.

e. Both clerk typist and file clerk. Turn to page 170, Box 3.

f. All positions except drafting. Turn to page 171, Box 1.

From page 143

1

Yes. He should be assigned to the Personnel Office job (#4) because it has the same starting time (7:30 a.m.) as his regular job.

Now turn to page 144 for the next task.

From page 160

2

He is qualified for the file clerk position. He has 4 years experience as a yeoman in the Navy and 90 classroom hours of clerical training. However this is not the only job he qualifies for.

Return to page 160 and make another selection.

From page 147

3

Correct. The best answer is reassign him to the position of Mark-Up Clerk. It best meets Mr. Saunders' new physical limitations.

Now turn to page 148 to begin a new case.

From page 140

4

Correct. Choice a, Office clerk, is the best match for his work limitations. His physical limitations include no lifting, no reaching above shoulders, and no stooping, kneeling, bending or climbing.

Turn to page 143 to continue the case.

TASK BOOK
LIGHT DUTY
RYAN CASE
TASK 3

You have determined that Mr. Ryan would be eligible for clerk-typist and file clerk positions at the GS-4 level. A staffing specialist identifies four series of positions which you have at your facility:

Mail and File Series - 305
Voucher Examining Series - 540
Property Disposal Series - 1107
Clerk-Typist Series - 322

Review the attached Requests for Personnel Action (SF-52's) to determine in which positions Mr. Ryan can be placed.

After reviewing the SF-52's, go on to page 166 to answer the question.

best copy available

Standard Form 52—Rev. July 1968
U.S. Civil Service Commission
FPM Ch. 295

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part *except those inside the heavy lines.* If applicable, obtain resignation and separation data on reverse side.

1. NAME (CAPS) LAST—FIRST—MIDDLE MR—MISS—MRS.	2. *(For agency use)*	3. BIRTH DATE *(Mo., Day, Year)*	4. SOCIAL SECURITY NO.

A. KIND OF ACTION REQUESTED: (1) PERSONNEL *(Specify appointment, reassignment, resignation, etc.)*	B. REQUEST NUMBER	C. DATE OF REQUEST
RECRUIT	839	3/29/83
(2) POSITION *(Specify establish, review, abolish, etc.)*	D. PROPOSED EFFECTIVE DATE: ASAP	E. POSITION SENSITIVITY: NS

5. VETERAN PREFERENCE (1—NO, 2—5 PT., 3—10 PT. DISAB., 4—10 PT. COMP., 5—10 PT. OTHER)	6. TENURE GROUP	7. SERVICE COMP. DATE	8. HANDICAP CODE

9. FEGLI (1—COVERED (REGULAR ONLY—DECLINED OPTIONAL), 2—INELIGIBLE, 3—WAIVED, 4—COVERED (REG. & OPT.))	10. RETIREMENT (1—CS, 2—FICA, 3—FS, 4—NONE, 5—OTHER)	11. *(For CSC use)*

12. NATURE OF ACTION — CODE	13. EFFECTIVE DATE *(Mo., Day, Year)*	14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY

15. FROM: POSITION TITLE AND NUMBER	16. PAY PLAN AND OCCUPATION CODE	17. (a) GRADE OR LEVEL (b) STEP OR RATE	18. SALARY

19. NAME AND LOCATION OF EMPLOYING OFFICE

20. TO: POSITION TITLE AND NUMBER	21. PAY PLAN AND OCCUPATION CODE	22. (a) GRADE OR LEVEL (b) STEP OR RATE	23. SALARY
Clerk-Typist P.D. #791048	GS-322	04 01	

24. NAME AND LOCATION OF EMPLOYING OFFICE
Public Works Dept
NAVAL Shipyard (code 407)
Norfolk, VA

25. DUTY STATION *(City—county—State)*	26. LOCATION CODE
Norfolk VA	

27. APPROPRIATION	28. POSITION OCCUPIED (1—COMPETITIVE SERVICE, 2—EXCEPTED SERVICE)	29. APPORTIONED POSITION FROM: (1—PROVED-1, 2—WAIVED-2) TO: STATE
00 181349	1	

F. REMARKS BY REQUESTING OFFICE *(Continue in item F on reverse side, if necessary)*
Vacancy created due to resignation of Sarah Fields

G. REQUESTED BY *(Signature and title)* *(Leave blank on resignations)*
Anne J. Whitfield

H. FOR ADDITIONAL INFORMATION—CALL *(Name and telephone number)*
X7159

I. REQUEST APPROVED BY:
SIGNATURE Earl Robertson
TITLE Head, Data Processing Office

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J. POSITION CLASSIFICATION ACTION: IDENTICAL ADDITIONAL ☐ NEW ☐ VICE ☐ REGRADED ☐

K. CLEARANCES	Initials or Signature	Date
(1)		
(2) CEIL. OR POS. CONTROL	jg	3/30
(3) CLASSIFICATION	jg	3/30
(4) PLACEMENT OR EMPL.		
(5)		
(6) APPROVED BY:		

(7) REMARKS *(Note: Use item 30 on reverse for Standard Form 50 remarks)*
QUALIFICATION STANDARD: X118

52-109

Standard Form 52—Rev. July 1968
U.S. Civil Service Commission
FPM Ch. 295

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part *except those inside the heavy lines.* If applicable, obtain resignation and separation data on reverse side.

1. NAME (CAPS) LAST–FIRST–MIDDLE — MR.–MISS–MRS.	2. *(For agency use)*	3. BIRTH DATE *(Mo., Day, Year)*	4. SOCIAL SECURITY NO.
		—	—

A. KIND OF ACTION REQUESTED: (1) PERSONNEL *(Specify appointment, reassignment, resignation, etc.)*	B. REQUEST NUMBER	C. DATE OF REQUEST
RECRUIT	431	3 28 83
(2) POSITION *(Specify establish, review, abolish, etc.)*	D. PROPOSED EFFECTIVE DATE: ASAP	E. POSITION SENSITIVITY

5. VETERAN PREFERENCE (1—NO, 2—5 PT., 3—10 PT. DISAB., 4—10 PT. COMP., 5—10 PT. OTHER)	6. TENURE GROUP	7. SERVICE COMP. DATE	8. HANDICAP CODE
9. FEGLI (1—COVERED (REGULAR ONLY—DECLINED OPTIONAL), 2—INELIGIBLE, 3—WAIVED, 4—COVERED (REG. & OPT.))	**10. RETIREMENT** (1—CS, 2—FICA, 3—FS, 4—NONE, 5—OTHER)		**11.** *(For CSC use)*
12. NATURE OF ACTION CODE	**13. EFFECTIVE DATE** *(Mo., Day, Year)*	**14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY**	

15. FROM: POSITION TITLE AND NUMBER	16. PAY PLAN AND OCCUPATION CODE	17. (a) GRADE OR LEVEL (b) STEP OR RATE	18. SALARY
19. NAME AND LOCATION OF EMPLOYING OFFICE			

20. TO: POSITION TITLE AND NUMBER	21. PAY PLAN AND OCCUPATION CODE	22. (a) GRADE OR LEVEL (b) STEP OR RATE	23. SALARY
P.D. 684930 SECRETARY (STENO)	GS-318	05 01	
24. NAME AND LOCATION OF EMPLOYING OFFICE			
Comptroller Dept (Code 390) Naval Shipyard Norfolk, VA.			

25. DUTY STATION *(City—county—State)*	26. LOCATION CODE
Norfolk, VA.	

27. APPROPRIATION	28. POSITION OCCUPIED (1—COMPETITIVE SERVICE, 2—EXCEPTED SERVICE)	29. APPORTIONED POSITION FROM: (1—PROVED-1, 2—WAIVED-2) TO: STATE
00181349	1	

F. REMARKS BY REQUESTING OFFICE *(Continue in item F on reverse side, if necessary)*

Vacancy created by promotion of incumbent

G. REQUESTED BY *(Signature and title)* *(Leave blank on resignations)*
Irene M. Jones, Code 390

H. FOR ADDITIONAL INFORMATION—CALL *(Name and telephone number)*
x4982

I. REQUEST APPROVED BY:
SIGNATURE: E. L. Kuhn
TITLE: Asst. Comptroller Dept.

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J. POSITION CLASSIFICATION ACTION: IDENTICAL ADDITIONAL ☐ NEW ☐ VICE ☐ REGRADED

K. CLEARANCES	Initials or Signature	Date
(1)		
(2) CEIL. OR POS. CONTROL	llm	3/29/83
(3) CLASSIFICATION	jj	4/1/83
(4) PLACEMENT OR EMPL.		
(5)		
(6) APPROVED BY:		

(7) REMARKS: *(Note: Use item 30 on reverse for Standard Form 50 remarks)*
QUALIFICATION STANDARD: X118

52-109

Standard Form 52—Rev. July 1968
U.S. Civil Service Commission
FPM Ch. 295

REQUEST FOR PERSONNEL ACTION

PART I. REQUESTING OFFICE: Unless otherwise instructed, fill in all items in this part *except those inside the heavy lines.* If applicable, obtain resignation and separation data on reverse side.

1. NAME (CAPS) LAST—FIRST—MIDDLE MR.—MISS—MRS.	2. *(For agency use)*	3. BIRTH DATE *(Mo., Day, Year)*	4. SOCIAL SECURITY NO.

A. KIND OF ACTION REQUESTED: (1) PERSONNEL *(Specify appointment, reassignment, resignation, etc.)*	B. REQUEST NUMBER	C. DATE OF REQUEST
Recruit	854	3 9 84
(2) POSITION *(Specify establish, review, abolish, etc.)*	D. PROPOSED EFFECTIVE DATE ASAP	E. POSITION SENSITIVITY

5. VETERAN PREFERENCE 1—NO 2—5 PT. 3—10 PT. DISAB. 4—10 PT. COMP. 5—10 PT. OTHER	6. TENURE GROUP	7. SERVICE COMP. DATE	8. HANDICAP CODE
9. FEGLI 1—COVERED (REGULAR ONLY—DECLINED OPTIONAL) 2—INELIGIBLE 3—WAIVED 4—COVERED (REG. & OPT.)	10. RETIREMENT 1—CS 2—FICA 3—FS 4—NONE 5—OTHER		11. *(For CSC use)*
12. NATURE OF ACTION CODE	13. EFFECTIVE DATE *(Mo., Day, Year)*	14. CIVIL SERVICE OR OTHER LEGAL AUTHORITY	

15. FROM: POSITION TITLE AND NUMBER	16. PAY PLAN AND OCCUPATION CODE	17. (a) GRADE OR LEVEL (b) STEP OR RATE	18. SALARY
19. NAME AND LOCATION OF EMPLOYING OFFICE			

20. TO: POSITION TITLE AND NUMBER	21. PAY PLAN AND OCCUPATION CODE	22. (a) GRADE OR LEVEL (b) STEP OR RATE	23. SALARY
MAIL & FILE CLERK P.D.# 81491	GS-305	04 01	
24. NAME AND LOCATION OF EMPLOYING OFFICE Administrative Dept. (Code 390) NAVAL SHIPYARD Norfolk, Va.			

25. DUTY STATION *(City—county—State)* Norfolk, Va			26. LOCATION CODE
27. APPROPRIATION 00181349	28. POSITION OCCUPIED 1—COMPETITIVE SERVICE 2—EXCEPTED SERVICE	29. APPORTIONED POSITION FROM: TO: 1—PROVED-1 2—WAIVED-2	STATE

F. REMARKS BY REQUESTING OFFICE *(Continue in item P on reverse side, if necessary)*

New position

G. REQUESTED BY *(Signature and title)* *(Leave blank on resignations)* James Wardaker, Admin Dept.

H. FOR ADDITIONAL INFORMATION—CALL *(Name and telephone number)* X7201

I. REQUEST APPROVED BY: SIGNATURE J. H. Cooper,

TITLE: CAPT. USN

PART II. TO BE COMPLETED BY PERSONNEL OFFICE (Items inside heavy lines in Part I above also to be completed)

J. POSITION CLASSIFICATION ACTION ☐ IDENTICAL ADDITIONAL ☐ NEW ☐ VICE ☐ REGRADED

K. CLEARANCES	Initials or Signature	Date
(1)		
(2) CEIL. OR POS. CONTROL		4/1
(3) CLASSIFICATION		4/1
(4) PLACEMENT OR EMPL.		
(5)		
(6) APPROVED BY:		

(7) REMARKS: *(Note: Use item 30 on reverse for Standard Form 50 remarks)*

QUALIFICATION STANDARD: X118

52-109

Circle the letter below in front of the positions for which Mr. Ryan can qualify:

a. Clerk Typist. Turn to page 168, Box 1.

b. Secretary (steno). Turn to page 167, Box 3.

c. Mail and File Clerk. Turn to page 169, Box 2.

d. Both the clerk typist and mail and file clerk. Turn to page 171, Box 2.

e. All three positions (a - c). Turn to page 170, Box 1.

From page 147

1

No. The physical requirements for the position of Office Clerk are now far below his capabilities.

Return to page 147 for another try.

From page 143

2

No, not the closest to his regular working conditions.

Return to page 143 for another try.

From page 166

3

No. He does not have sufficient stenographic skills for this position.

Return to page 166 and try again.

From page 160

4

Correct. Clerk typist - 4 years experience as a yeoman in the Navy and 160 classroom hours of typing. He also types 41 words per minute. However, this is not the only job he qualifies for.

Return to page 160 and make another selection.

From page 166

1

Yes. He qualifies as a clerk typist, but not only for this job.

Return to page 166 and try again.

From page 147

2

No. The lifting and standing requirements for the position of File Clerk are beyond his capabilities.

Return to page 147 for another try.

From page 160

3

No. Personnel specialist - although he worked in personnel office his duties were essentially clerical.

Return to page 160 and try again.

From page 143

4

No. This is not the best choice. What conditions of this job are different from his regular job.

Return to page 143 for another selection.

From page 143

1

No. This isn't the closest to the conditions of his regular job.

Return to page 143 for another try.

From page 166

2

Yes he does qualify for this job, but not this job alone.

Return to page 166 for another try.

From page 160

3

No. Drafting - 40 hours of basic classroom training. This would be insufficient to qualify him for a technician position.

Return to page 160 and try again.

From page 78

4

Not correct. Return to page 78 and make another selection.

From page 166

1

No. He does not qualify for all three.

Return to page 166 to pick another answer.

From page 20

2

Not really. Although there may be witnesses, the best source of finding them would be through the claimant.

Return to page 20 for another try.

From page 160

3

Correct. He is qualified for the clerk typist position. He has 4 years experience as a yeoman in the Navy and 160 classroom hours of typing. He also types 41 words per minute.

and

He qualifies for the file clerk position because of his 4 years experience as a yeoman in the Navy, plus 90 classroom hours of clerical training.

Now turn to page 162 for the next task in this case.

4

From page 160

1

Not quite. It is true that he does not qualify in drafting. He has only 40 hours of basic classroom training. This would be insufficient to qualify him for a technician position. However, he does not qualify for all three of the other jobs.

Return to page 160 and try again.

From page 166

2

Correct. Mr. Ryan can qualify for the Mail and File Clerk and Clerk-Typist positions. These are the types of positions he held previously and they are GS-4 positions.

This is the end of this module. Turn to page 172 to begin a new module.

3

4

TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 1

Read the Resource Book, pages 48 - 53.

a. Read the chart below which duplicates the chart on page 52 of the Resource Book. If the dollar figures seem very unrealistic for your area, cross them out on the chart below and insert the dollar figures you would use.

INDICATORS FOR POSSIBLE PAYMENT ERRORS

If:	Higher than normal compensation payments
Then:	Verify that payments are correct
If:	Very high medical costs ($10,000 or more)
Then:	Check medical costs for duplicate payments or billing errors.
If:	High medical costs (over $1,000) and no compensation
Then:	Check for duplicate payments or billing errors.

b. Review the chargeback billing list on the following page. Identify cases for possible payment errors only. Use the rules in the chart above for this task. List below the claimants whose payments may be in error and your reason for selecting them. The average full compensation range for this agency is $12,000 to $20,000. Refer to the chart on page 52 of the Resource if you need to. As you work with the pages of chargeback lists, you might want to use a ruler or a straight edge.

NOTE: On the chargeback lists used for these cases, to save space the last 2 columns for the total number and amount of payments have been deleted.

AFTER YOU HAVE WRITTEN YOUR ANSWERS, TURN TO PAGE 174 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

DV1PCB40

REPORT DATE: 07/31/83 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1982-JUNE 30, 1983

DEPARTMENT: TENNESSEE VALLEY AUTHORITY

AGENCY: POWER

ACCOUNT: DIVISION OF POWER PRODUCTION

ACCOUNT NUMBER: 1550

PD		EMPLOYEE NAME			DATE OF INJURY	PAYMENTS ---MEDICAL--- NO.	AMOUNT	---COMPENSATION NO.	AMOUNT	ROLL	ADJ
17		FELTY	PHILLIP	E	12/04/78			15	6,336.05-	D	
17		BROWN	LEE	R	11/18/78	2	44.00	14	12,367.50	P	
06		CROW	CHARLES	W	12/18/78	3	435.00	14	6,403.60	P	
06		BURKS	IRWIN	W	01/05/79	2	145.00	14	14,373.32	P	
06		LAWSON	HILTON	M	12/03/78	1	260.00	14	8,692.35	P	
06		LEE	JOE	W	02/01/79			1	3,035.48	S	
06		ROBINETT	WILFORD	E	02/02/79	1	13.50				
17		COLE	JAMES	R	03/06/79			14	11,476.13	P	
06		DOVER	ALBERT	E	02/23/79	8	382.65	14	33,372.32	P	
06		LEE	LESTER	L	10/26/78	10	598.00	14	49,317.70	P	
17		SLAVEN	BEVERLY	K	12/07/78	6	199.00	14	2,236.75	P	
06		BARLOW	JAMES	D	03/06/78	11	1,806.42				
17	*	BIERKAMP	RAYMOND	C	01/04/79	1	30.00				
06		BRAUN	HARRY	T	02/14/79	2	365.60	4	5,035.26	S	
06		HOFFMAN	MARTIN	L	02/17/79	5	345.84	15	19,225.61	P	
06		RALPH	RONALD	T	03/19/79			5	6,192.68	S	
06		BARTON	LV	C	04/09/79	21	3,692.71	14	16,071.26	P	
06		EDER	MARY	J	04/05/79	9	603.00	14	4,824.50	P	
06		CAMPBELL	GARY	W	04/18/79			1	431.20	S	
06		HOLLIFIELD	JOHN	E	03/14/79	5	2,393.45				
17		GILBERT	CHARLES	W	04/02/79	1	16.00	14	14,962.14	P	
06		GUNNING	KENNETH	G	05/08/79	13	220.34	14	19,604.64	P	
06		PENTECOST	ARTHUR	L	05/20/79	4	27.80	11	4,778.04	P	
06		ADCOCK	LARRY	R	05/11/79	9	908.90	14	15,449.28	P	*
06		BIVENS	BILLY	W	05/29/79	31	970.43	14	19,959.46	P	
06		MORRIS	BEN	L	07/18/79	33	7,499.54	11	18,954.05	P	
06		GASTON	JAMES	C	07/15/79	5	359.25	1	2,778.05	S	
06		MCMILLAN	JACK	D	07/03/79			1	1,121.05	S	
17		JOHNSON	RAYMOND	M	08/06/79	3	347.00	14	12,478.39	P	
06		FULLER	KENNETH	A	08/24/79	2	125.21				
17		DAVIS	BERNARD	L	12/01/79	38	28,866.89	14	10,902.10	P	
17		FERGERSON	JOHN	N	11/18/79	24	887.44	14	6,991.28	P	

CASE MATERIAL

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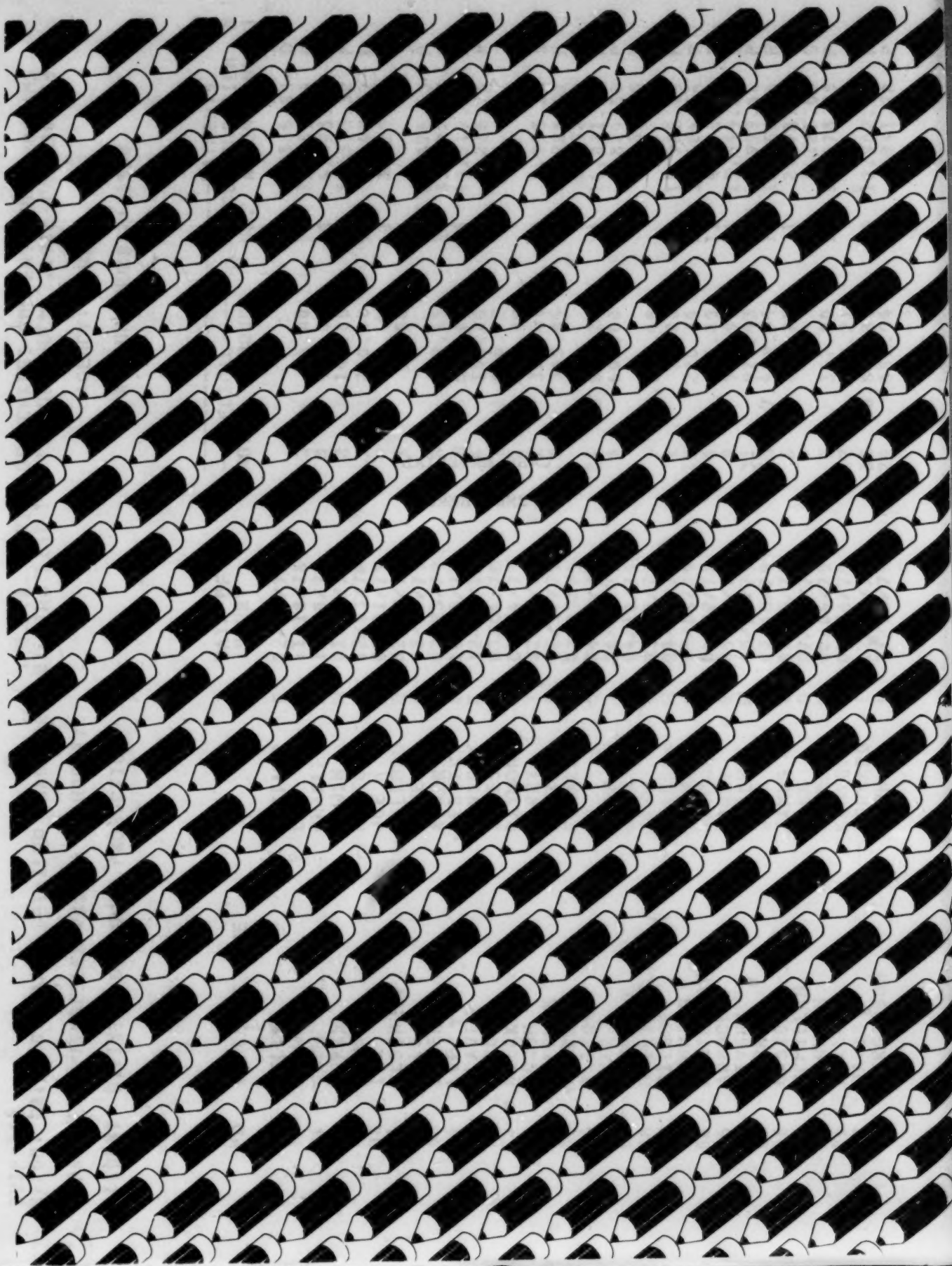


Answer:

The following are cases you would check for possible billing errors:

1. Albert Dover - High compensation amount of $33,372.32 appears higher than the normal compensation range for this agency.

2. Lester Lee - There was an extremely high amount of compensation paid to Mr. Lee - $49,317.70. This is above the compensation range for this agency.

3. James Barlow - Medical costs are over $1,000 and there are no compensation payments.

4. John Hollifield - There were high medical costs incurred ($2393.45) and no compensation payments.

5. Bernard Davis - Very high medical costs ($28,866.89).

You might be tempted to pick the following people, but would not for the reasons stated:

L. Barton. Although the medical payments are over $1,000, the rule says "high medical over $1,000 and no compensation". He received 14 compensation payments so you would not list him.

Ben Morris. Although his medical costs are high, they are not up to the $10,000 cut-off point and he does not meet the "over $1,000 and no compensation" rule.

TURN THE PAGE.

TASK BOOK
REVIEW OF CHARGEBACK LIST

In the next three segments, you will be moving back and forth between two different kinds of work.

First you will review part of an agency's annual chargeback list to identify cases that will need to be reviewed. Then you work with an actual file on one of the cases you have identified and make some decisions about it.

This cycle will be repeated.

TURN THE PAGE TO BEGIN THE NEXT TASK.

TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 2
TASK 1

Read the Resource Book, pages 54 - 56. This section deals with reviewing cases for continuing disability.

Review the following page from the Chargeback Billing List. For this task, assume that today's date is April 1, 1984. Also assume that normal full compensation range for this agency is $10,500 to $20,000.

a. List those priority cases to review for continuing disability. (For this task do not list cases for possible overpayments.) If you want to consult the Resource, refer to the chart on page 56.

b. Give your rationale for your selections. Write your answers below.

NOW COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS ON PAGE 178.

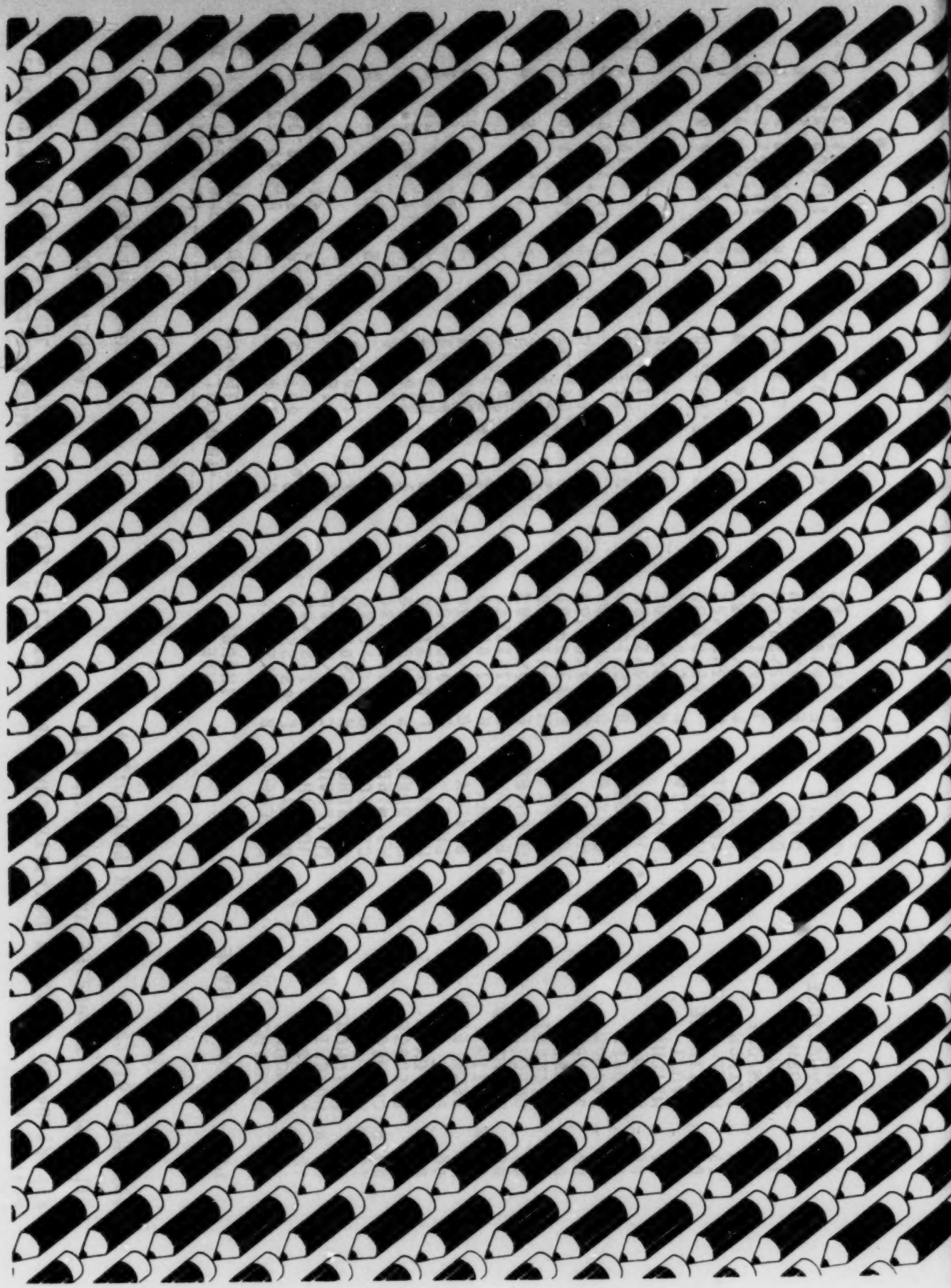
bv1PCB40 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS
REPORT DATE: 07/31/83 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1982-JUNE 30, 1983

DEPARTMENT: TENNESSEE VALLEY AUTHORITY AGENCY: POWER

ACCOUNT: DIVISION OF POWER PRODUCTION ACCOUNT NUMBER: 1550

PD		EMPLOYEE NAME			DATE OF INJURY	PAYMENTS ---MEDICAL--- NO.	AMOUNT	---COMPENSATION NO.	AMOUNT	ROLL	A - D J
06		PENLAND	EUGENE	B	04/29/79	4	154.00	4	5,989.35	P	
06		NEWCOMB	DANNY	L	02/22/80	10	699.75	14	17,899.96	S	
06		JACKSON	JUDITH	S	03/20/80			3	2,472.20	S	
06	*	HUTCHISON	WILLIAM	C	03/04/80	1	18.00				
06		HITCHCOX	CLARENCE	R	02/07/80	1	196.00				
17	*	HAM	CLIFFORD	O	04/16/80			2	14,485.30-	D	
06	*	CHAMBERS	RICHARD		02/15/80	1	40.00				
06		BLEDSOE	WILBURN	R	03/06/80	7	226.00	12	14,980.01	P	
06		RILEY	HOLLIS	L	03/21/80	8	237.01	4	5,903.88	S	
06		COOK	PHIL	S	04/03/80	3	147.80	14	18,445.53	S	
06		TEMPLETON	BAILEY	G	03/08/80	11	4,556.13	4	4,909.65	P	
06	*	SMITH	DANNY	R	03/06/80	5	1,055.17				
06		MAYFIELD	EDWIN	B	03/17/80	3	64.12				
06		DUBOIS	MICHAEL	E	04/22/82	19	2,655.42	1	1,342.20	S	
06		ATCHLEY	BILLY	W	04/16/80	1	22.00				
06		MANSELL	RICHARD	L	05/05/80	32	9,227.22	14	16,727.07	P	
06		JACKSON	ROE	B	05/08/82	18	2,087.04	12	17,541.58	S	
17		LATHAM	RONALD	G	08/07/80			14	18,726.00	D	
06		COOPER	JAMES	G	12/18/79	12	261.75	5	939.54-	S	*
06		ODOM	JAMES	C	06/24/82	1	10.00				
06		MITCHELL	LARRY	W	08/12/82	3	75.00				
		FAUTT	WILLIAM	P	11/05/79						
06		WHITMORE	MARVIN		02/03/83	27	3,285.25	1	1,546.80	S	
17		HALL	FREDDIE	W	03/01/62			14	11,595.92	P	
17		TAYLOR	AARON	P	03/20/81	1	40.00	14	11,439.92	P	
17		NEWSOME	WILLIAM	J	04/11/62			14	19,262.82	P	
17		CUMMINS	DAVE	H	03/29/62	3	272.95	14	17,159.89	P	
17		THORNTON	CARL	E	04/18/62			14	935.28	P	
17		STANDRIDGE	JAMES	R	06/01/62	2	92.00	14	15,362.82	P	
17		CROWE	JAMES	K	06/08/62			5	727.30	S	

TASK MATERIAL
ENDS HERE



TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 2
TASK 1

Answer:

The following cases need to be reviewed on medical grounds:

1. Bailey Templeton has received four compensation payments, but has very high medical costs $4,556.13 and a date of injury older than two years (3-08-80).

2. Richard Mansell has received 14 compensation payments and very high medical payments (32 of them for a total of $9,227.22) and his date of injury is prior to April 1, 1982.

3. Freddie Hall is on the periodic roll (received 14 payments) yet had no medical costs.

4. Aaron Taylor is receiving full compensation and had low medical payments (only $40.00 which would be one or two office visits.

5. William J Newsome - Although he is on the periodic roll for being totally disabled, he is incurring no medical costs.

6. James Standridge is on the periodic roll (determined from 14 payments), but has low medical payments (less than $92.00).

You would not select Michael Dubois, Roe Jackson, or Marvin Whitmore whose medical payments are over $2,000 - their dates of injury are not prior to April 1, 1982.

You would not pick Ronald Latham's case with full compensation and no medical because it is a death case.

You would not pick Judith Jackson or James Crowe because they do not have 14 or more compensation payments.

You would not select Danny Newcomb or Phil Cook because they do not have over 14 compensation payments - they have just 14 which is normal.

You would not choose Carl Thornton's case with no medical payments because the low compensation rate of $935.28 indicates he is probably LWEC.

TURN THE PAGE AND DO THE NEXT TASK.

TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

Read the Resource Book, pages 58 - 63 on Long Term Case Review.

You get the case of Aaron Taylor to review. You find that he is receiving total disability compensation for back sprain incurred on 3/20/81. The $40.00 medical expense was for an office visit to his physician on 6/6/82. (See Dr. Steward's report of that exam on the following page.)

The file also contains a medical report dated 8/12/82 and an OWCP 5 (Work Restriction Evaluation) dated 9/30/82.

No other more recent medical evidence is in the file.

Examine these documents on the following three pages, then go to page 183 to answer the question.

STANLEY L. STEWARD, M.D.
812 Market Street
Greenville, Kentucky

Re: Aaron Taylor

June 6, 1982

To Whom It May Concern:

Mr. Taylor returns today stating his back is no better. He states the walking and exercise program I recommended has been of no benefit. Mr. Taylor feels he is unable to work.

Impression: Lumbar disc syndrome

S. L. Steward, M.D.

TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

STANLEY L. STEWARD, M.D.
812 Market Street
Greenville, Kentucky

Re: Aaron Taylor 085

August 12, 1982

Office of Workers' Compensation Programs:
Jacksonville, Florida

This is to respond to your request for my findings during the June 6 evaluation of Mr. Taylor.

Mr. Taylor reported he was always in pain and felt he would never be able to return to work. X-rays were within normal limits as was his range of motion. Any pressure I applied to the lumbar area caused Mr. Taylor pain from tenderness.

Mr. Taylor's continuous pain and lack of desire to work leads me to feel he would be a poor candidate to return to any type of gainful employment.

S. L. Steward, M.D.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name (First, middle, last): Aaron Taylor

2a. OWCP No. A7-085

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. Sitting				✓							
b. Walking			✓								
c. Lifting			✓								
d. Bending			✓								
e. Squatting			✓								
f. Climbing			✓								
g. Kneeling			✓								
h. Twisting			✓								
i. Standing			✓								

4. Check the lifting restriction.
☒ 0–10 lbs. ☐ 10–20 lbs. ☐ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☐ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☒ Yes ☐ No

5c. Pushing and pulling? ☒ Yes ☐ No

5d. Fine manipulation? ☐ Yes ☒ No

6. Can the worker reach or work above the shoulder? ☐ Yes ☒ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☐ Yes ☒ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☐ Yes ☒ No

9. Are there cardiac, visual, or hearing limitations?
☐ No ☒ Yes – *(Describe)* being tested for this condition per Client

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dusts, fumes or gases?
☐ No ☒ Yes – *(Describe)* degradates
Client must guard against cold weather Back pain

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☐ No ☐ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☐ Yes ☒ No – *(Indicate when)*

12b. If not eight hours, how many and when?
none

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☐ Yes ☒ No has had VR

14. Has the worker reached maximum improvement?
☒ Yes *(Indicate when)* 6 mos. ago surgery ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)*

16. Name: S. L Steward

17. Signature:

18. Address: 812 Market Street, Greenville Kentucky

19. Telephone No.: 889-4732

20. Date: 4/30/82

Copy Distribution: WHITE – Carrier/Employer YELLOW OWCP Case File PINK – OWCP Rehab. File

GPO 981 946

Form OWCP-5
Sept. 1979

TASK BOOK
REVIEW OF CHARGEBACK LIST
TAYLOR CASE
TASK 1

a. Is the medical evidence for Aaron Taylor sufficient to justify continuing disability for work?

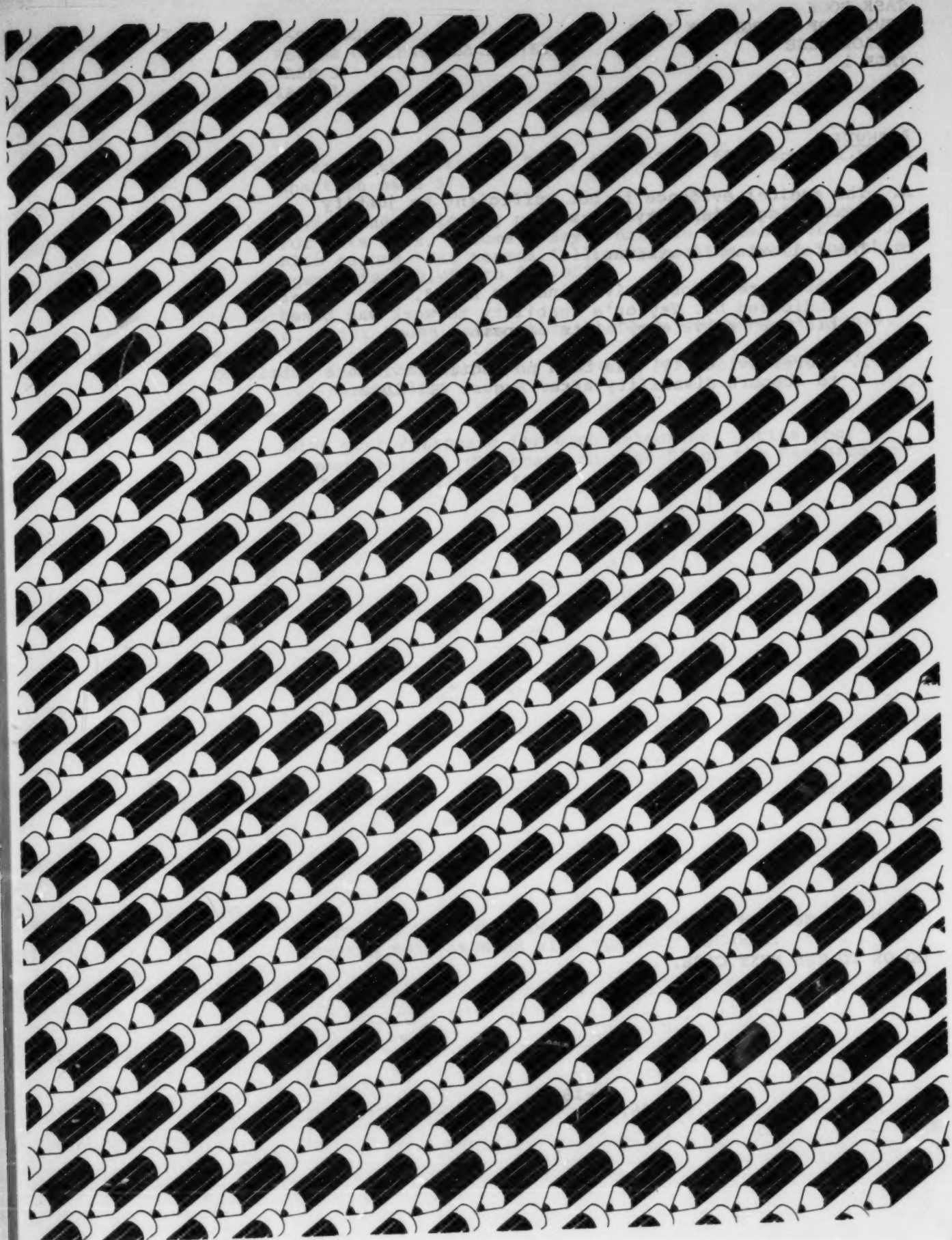
b. 1) If yes, why is it?

2) If no, what specifically is missing?

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWERS TURN TO PAGE 184 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

TASK MATERIAL ENDS HERE



Answer:

a. The medical evidence is not sufficient to justify continuing disability for work.

b. The following is missing:

1. There are no objective findings noted. Dr. Steward indicated Mr. Taylor's inability to work was based on his subjective complaints of pain.

2. There, evidently, has been no medical evidence submitted to support disability after August 12, 1982.

GO ON TO THE NEXT CASE.

TASK BOOK
REVIEW OF CHARGEBACK LIST
CASE 3
TASK 1

Refer to the Resource Book, pages 50 - 57, especially the chart on page 57.

Review the following page from a chargeback billing list. For this task, assume today's date is November 28, 1983. Also assume that normal full compensation range for this agency is $10,000 to $23,000.

a. List those cases where there may be payment errors.

b. List those priority cases to review for continuing disability.

Give your rationale for each selection. Write your answers below. The chart on page 57 of the Resource may be helpful for this task.

AFTER YOU HAVE WRITTEN YOUR ANSWERS GO TO PAGE 187 TO COMPARE YOUR ANSWERS WITH THE BOOK ANSWERS.

DV1PCB40
REPORT DATE: 07/31/83 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS
DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1982-JUNE 30, 1983

DEPARTMENT: TENNESSEE VALLEY AUTHORITY

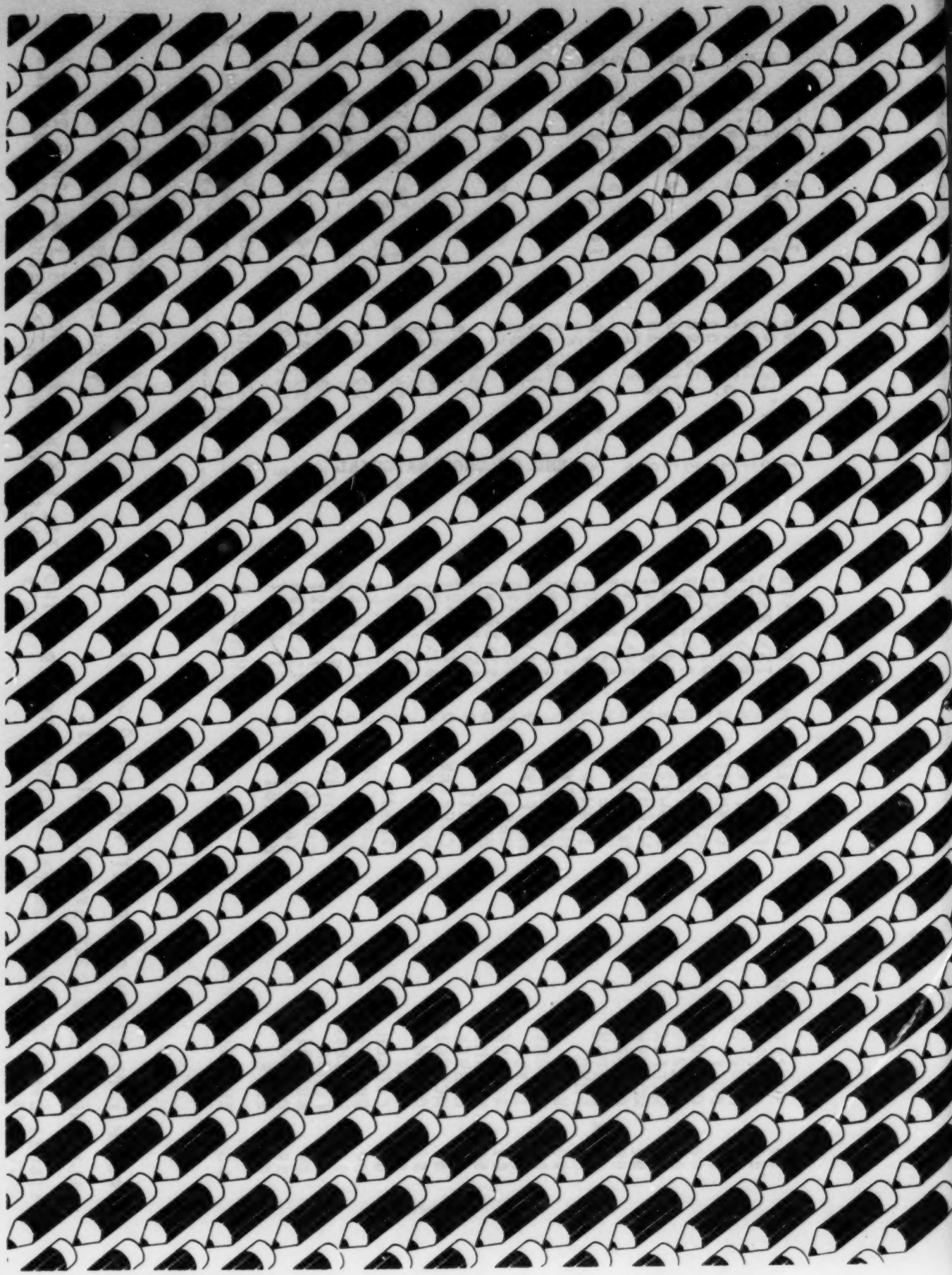
AGENCY: POWER

ACCOUNT: DIVISION OF FOSSIL AND HYDRO POWER

ACCOUNT NUMBER: 1553

PD		EMPLOYEE NAME			DATE OF INJURY	PAYMENTS ---MEDICAL--- NO.	AMOUNT	PAYMENTS ---COMPENSATION NO.	AMOUNT	ROLL	ADJ
06		EVANS	ROBERT	H	01/13/81	16	1,296.08				
06		HICKS	KENNITH	A	12/27/80	29	4,236.88	14	18,436.17	P	
06		ROBERTS	DANNY	L	01/01/81	1	69.50				
06		LOUDY	RICHARD		08/15/80			14	18,726.00	P	
06	*	FORTNER	ROY	D	12/09/80	2	537.00-				
06		BREECE	CHARLES	L	01/19/81			14	22,131.21	P	
06		CROUCH	JIMMY	E	03/09/81	22	17,209.69	14	20,353.28	P	
06		ARMS	JOE	E	03/19/81	1	30.00				
06		GREEN	WILLIAM	L	03/20/81	1	798.95				
06		MCMURTRY	CHESTER	D	03/04/81	2	50.00				
06		HORNER	DIXIE	B	02/19/81	4	327.27				
06		HOLAWAY	DARYL	D	02/25/81	1	9.20	2	2,496.51	P	
06		BERUBE	CECIL	L	02/26/81	1	8.00				
06		THARP	WILLIAM	B	04/03/81	1	18.00				
06		MCGOWAN	CHARLES	L	02/04/81	2	105.75				
06		RUST	WILLIAM	H	04/01/81	3	66.58				
06		LONG	THOMAS	H	04/07/81	24	12,141.66	14	14,198.22	S	
06	*	BATSON	JUDE	W	03/10/81			2	2,258.50-	S	*
06		GOLDSBY	MICHAEL	C	04/22/81	1	38.50				
06		MORGAN	MICHAEL	G	04/09/81	3	1,543.90				
06		MILLAY	THOMAS	A	04/16/81	3	215.50	16	19,439.31	S	
06		PRESSON	DONALD	H	04/23/81	2	32.00	3	2,472.54	P	
06		GIBSON	WILLIAM	T	05/06/81	1	65.00				
06		BELL	GRANVILLE	R	05/14/81	3	225.60	4	7,370.72	S	
06		HENSLEY	WILLIAM	R	04/30/81	1	18.00	4	593.64	P	*
06		COLLINS	LEE	R	12/18/82	29	4,285.09	14	20,353.28	P	
06		HUDDLESTON	CHESTER	W	10/29/80	1	92.00	14	20,353.28	P	

END OF CASE MATERIAL



Answer:

a. The following cases should be reviewed for possible payment errors:

Robert Evans. His medical costs are over $1,000 and there are no compensation costs.

Jimmy Crouch. Medical payments are very high (over $10,000) - $17,209.69.

Thomas Long. Medical payments are over $10,000.

Michael Morgan. High medical costs and no compensation costs.

b. The following cases should be reviewed for continuing disability:

Kennith Hicks. His medical costs are high (over $2,000) and his date of injury is over 2 years old.

Richard Loudy. He is receiving full compensation and has no medical costs.

Charles Breece. He is receiving full compensation and has no medical costs.

Jimmy Crouch. He is receiving full compensation, has high medical costs, and his date of injury is over 2 years old.

Thomas Long. High medical costs of $12,141.66 and date of injury is over 2 years old.

Chester Huddleston. He is receiving full compensation and has only $92.00 in medical costs.

You notice that Jude Batson has no medical costs and the date of injury is over 2 years old. But you would not select him because he did not receive full compensation (14 payments).

Although his medical costs are high ($4,285.09), you would not select Lee Collins because his date of injury is not older than November 28, 1982

GO ON TO THE NEXT TASK.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 1

In reviewing the latest chargeback list you identified several cases for review. One of these is the case of Virginia Williams. You pull the file and find that Ms. Williams's case was accepted for back strain due to a 1980 injury. She was separated from the agency on 6-1-81. Assume today's date to be Dec. 4, 1983.

If you need to refer to the Resource Book, the reference material can be found on pages 58 - 62.

Review the most recent medical report on the following page and answer question below:

Does the medical evidence adequately support continuing disability?

a. Yes. Turn to page 211, Box 3.

b. No. Turn to page 212, Box 1.

MEDICAL REPORT

PATIENT: Virginia Williams
Date: 3/14/81

Patient was seen by me this date complaining of continuing back pain. As I have diagnosed earlier, Ms. Williams is suffering from degenerative arthritis of the spine, as well as from diabetes.

Blood test results show continued high sugar level. I prescribed daily injections of insulin, to be continued indefinitely. I emphasized the need to continue with her controlled diet.

Bending and stooping caused patient considerable pain. In fact, patient complains that she is in pain most of the time.

I advised patient to apply moist heat to the back, and prescribed FIORINAL for pain.

Patient continues to be disabled for work.

J. H. Rider, M.D.
Internal Medicine
3/14/81

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE
TASK 2

The medical report on page 189 is adequate in which of the following areas? Circle the letter of your answer, then turn to the referenced page.

a. It contains objective findings. Turn to page 253, Box 4.

b. The medical evidence is current. Turn to page 273, Box 3.

c. There is adequate support for total disability. Turn to page 212, Box 2.

d. The disability is linked to a job injury. Turn to page 252, Box 1.

e. None of the above. Turn to page 252, Box 3.

What action would you take next?

a. Order a Fitness for Duty medical exam. Turn to page 253, Box 2.

b. Request OWCP to get an updated medical report addressing the inadequacies of the 3-14-81 report. Turn to page 211, Box 2.

c. Write to Dr. Rider asking him to provide the missing information. Turn to page 252, Box 1.

d. Order Ms. Williams to report to work. Turn to page 212, Box 4.

TASK BOOK
REVIEW OF CHARGEBACK LIST
WILLIAMS CASE

EXAMPLE

District Director
OWCP
3010 11th Street, N.W.
Washington, D.C. 30510

Re: Williams, Virginia, Claim #024376

Dear Sirs:

I am writing in regard to the above named claimant who is being paid compensation by your office. Ms. Williams sustained a severe muscle strain to her back in 1980.

The most recent medical report in our files shows that on the date of the most recent examination, 3/14/81, Ms. Williams was suffering from osteoarthritis, i.e., degenerative arthritis of the spine, and diabetes.

In view of the lack of current medical evidence specifically showing how her disability relates to the residuals of her 1980 injury, please have her submit new medical evidence.

We request that the results of this examination be carefully reviewed to determine if her current disability is in any way related to the 1980 injury. If not, we request cessation of medical benefits. Please advise.

Sincerely,

Edith Rogers,
Head, Compensation Branch

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

Review the Resource pages 58 - 63 if you need to.

In reviewing the current chargeback billing list you identified the case of Mary Parker to review on medical grounds. The claimant has been taken off the agency's rolls. You are now going to review her case file. Assume today's date is August 15, 1984.

Review the following file documents (pages 194 - 209). Then answer the question on page 210.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3.	4. Social Security Number
Parker, Mary H.	5/1/54	☐ Male ☑ Female	218-04-1926

5. Employee's Home Mailing Address (No., street, city, state, zip code)
606 Meadow View Rd
Portsmouth, Va 23709

6. Home Telephone
Area Code: 804
Number: 488-2121

7. Name and Address of Employing Agency
Norfolk Naval Shipyard
Industrial Relations Office
Portsmouth, Va 23709

8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Supply Room
Bldg 264

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
4/30/78 ☑ AM ☐ PM	5/1/78	Wife/Husband ☑ Children Under 18 Years Old ☑	Clerk-Typist

13. Cause of Injury (Describe how and why the injury occurred)
I had gotten up on ladder to reach a ream of paper when my foot slipped and I fell off ladder onto my right hip

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Right Hip + ~~Back~~

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Mary H. Parker
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)
I was walking by the supply room when I heard a crash. I observed Mrs. Parker on the floor. She advised me she had injured her back.

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Ann Smith	10 Park Place Portsmouth Va. 23709	5/1/78

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
NAVY	Norfolk Naval Shipyard

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Industrial Relations Office
Portsmouth, Va 23709

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 7:20 ☑ AM ☐ PM Ends 3:30 ☐ AM ☑ PM	8	S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
4/30/78 10:00 ☑ AM ☐ PM	5/1/78	5/2/78	

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor At Time of Injury
5/2/78	$5.00 per hour	Still out ☐ AM ☐ PM	Gloria Spicer

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee Is Disabled For Work?
5/2/78	Dr. T. A. Baker 11 Armstrong Square Portsmouth, Va 23709	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor	44. Title and Office Phone Number	45. Date *(mo., day, year)*
Gloria Spicer	Head, Supply Dept	5/10/78

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr. T. A. Baker
11 Armstrong Rd
Portsmouth, Va

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Parker, Mary H.	4/30/78	Clerk-typist

5. DESCRIPTION OF INJURY OR DISEASE

"I had gotten up on ladder to reach a ream of paper when my foot slipped and I fell about 4' injuring right h.p.

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL. (Sign all copies)	9. TITLE
Billy Gallup	Head, Employee Services
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
(804) 396-7886	5/1/78
12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	**13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.**
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Bureau or Office Local Address (Including Zip Code)

FORM CA–16
(REV. DEC. 1974)

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*
Parker, Mary H.

2. Social Security Number
218-04-1926

3. OWCP File Number *(If known)*
A25-100000

4. Is Claim Being Made For Wage Loss?
☑ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body?
☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*
From: 6/15/78 Through: 7/15/78

7. Has Any Pay Been Received For The Period Shown In Item 6?
☐ Yes ☑ No If Yes, State
Full Amount And Inclusive Dates For Such Period *(Mo., day, year)*
$ _____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States?
☐ Yes ☑ No If Yes, Furnish →

a. Service Number	b. Branch Of Service	c. Period Of Service *(Mo, day, year)*
		From: _____ Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service?
☐ Yes ☑ No If Yes, Furnish →

a. Claim Number	b. Address of VA Office Where Claim Is Filed	c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law?
☐ Yes ☑ No If Yes, Furnish →

a. Claim Number	b. Date Annuity Began *(Mo., day, year)*	c. Amount of Monthly Payment
		$ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Bob Parker	Husband	12/1/50	Yes	

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature	16. Employee's Home Mailing Address *(Include Zip Code)*	17. Date *(Mo., day, year)*
Mary H. Parker	606 Meadow View Rd Portsmouth, Va 23709	6/15/78

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*
Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, Va 23709

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$5.25 per hour	$ per	$ per	$ per
Date Employee Stopped Work →	$5.25 per hour	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type N/A $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☑ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service
10 years

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*
—	—	—

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$5.25 per hour

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave
From: 5/1/78 Through: 6/14/78

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$2,348.02

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
N/A	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
6/15/78 ☑ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 6/15/78 Through: 7/15/78

32. Deductions:

a. Was Employee Enrolled On Date Pay Stopped? — Health Benefits: ☑ Yes ☐ No; Optional Insurance: ☐ Yes ☑ No

b. If Yes, Furnish Code Number. — 102

c. If Yes, Give Date Through Which Deductions Were Last Made.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
Still Out ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ _____ per _____

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Billy Dallas	Head, Employee Services (804) 396-2808	6/16/78

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Parker, Mary H.

2. HOME MAILING ADDRESS (Number, street, city, state, zip code): 6006 Meadow View Rd Portsmouth Va 23709

3. DATE AND HOUR OF INJURY (Mo., day, year): 4/30/78 ☑ AM ☐ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year): FROM 6/15/78 TO 7/15/78

5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE YOU?
Fell OFF Ladder injuring right hip.

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
Lumbosacral Spine Sprain Superimposed on spondolosithesis, Muscle spasms

7. WHAT IS YOUR DIAGNOSIS?
Same as above

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☑ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☐ YES ☑ NO
IF YES, DATE OF ADMISSION (Mo., day, year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☑ NO

11. OPERATIONS (If any, describe type): N/A

12. DATE OPERATIONS PERFORMED (Mo., day, year): N/A

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Examination, medication, physical therapy

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unknown at this point

15. DATE OF FIRST EXAMINATION (Mo., day, year): 5/2/78

16. DATES OF TREATMENT (Mo., day, year): 6/13/78—

17. DATE OF DISCHARGE FROM TREATMENT (Mo., day, year):

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 4/30/78 TO Present
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., day, year)
LIGHT WORK
REGULAR WORK N/A

20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.
N/A

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.

23. SIGNATURE OF PHYSICIAN: T. A. Baker

24. ADDRESS (Number, street, city, state, zip code): 11 Armstrong Square Portsmouth, Va 23709

25. DATE OF REPORT (Mo., day, year): 6/14/78

CA-20
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*: Parker, Mary H.

2. OWCP FILE NUMBER, IF KNOWN: A25-100000

3. HOME MAILING ADDRESS *(Include zip code)*: 606 Meadow View Rd, Portsmouth, Va 23709

4. SOCIAL SECURITY NUMBER: 218-04-1926

5. DATE AND HOUR OF INJURY *(Mo., day, year)*: 4/30/78 — 10 ☑ AM ☐ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)*: FROM: 7/16/78 THROUGH: 8/16/78

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6.?
☐ YES ☑ NO IF YES, COMPLETE ITEM 8.

8. AMOUNT RECEIVED $_____
DATES COVERED BY LEAVE PAY
FROM: THROUGH:

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER
		N/A		

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS

N/A

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

N/A

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

N/A

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO. AMOUNT OF MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

N/A

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF: Mary H. Parker

15. DATE *(Mo., day, year)*: 7/16/78

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $5.35 per 100
Stock Number 029-016-00022-4

Form CA-8 Revised Nov. 1974

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)* ☐ AM ☐ PM
Still Out

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY
| S | M | T | W | T | F | S |

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6. ON THE REVERSE SIDE?
☐ YES ☑ NO

19. IF ANSWER TO ITEM 18. IS YES, SHOW:
AMOUNT: $
TYPE OF PAYMENT:
PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

N/A

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(Mo., day, year)*
Billie Gallup	Head, Employee Services	7/18/78

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1. through 15. on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16. through 24. and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1. through 6. on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3. on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.

Form CA-8 Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)	2. OWCP FILE NUMBER, IF KNOWN
Parker, Mary H.	A25- 100000
3. HOME MAILING ADDRESS (Include zip code)	**4. SOCIAL SECURITY NUMBER**
606 Meadow View Rd Portsmouth, VA 23709	218-04-1926

5. DATE AND HOUR OF INJURY (Mo., day, year)	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year)
4/30/78 10:00 ☐ AM ☐ PM	FROM: 7/16/78 THROUGH: 8/16/78

7. DATE OF MOST RECENT EXAMINATION (Mo., day, year)	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED?	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK?
8/2/78	☑ YES ☐ NO	☑ YES ☐ NO

10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	11. STATE DIAGNOSIS
Chronic back problem	Lumbosacral Spine Sprain superimposed on spondylolisthesis, muscle spasms

12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?
Medication, physical therapy - 3 times a day

13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?	14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
Unknown	N/A

15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☑ YES ☐ NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)	16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? ☐ YES ☐ NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)

17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)	18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.

19. RECOMMENDATIONS AND PROGNOSIS
Continue to be rechecked on monthly basis
Continue on medication for muscle spasms and continue physical therapy three times a week

20. ADDRESS (Include zip code)	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
11 Armstrong Square Portsmouth, Va	Orthopedics
22. SIGNATURE OF PHYSICIAN	**23. DATE OF REPORT (Mo., day, year)**
T. A. Baker	8/3/78

Form CA-20a Revised Nov. 1974

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

December 1, 1979

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

This patient was examined by me on 12/1/79. Chief complaints continue to be that of stiffness and pain in the lower back region.

New X-rays were taken but revealed nothing new. Straight leg raising was 40° and muscle spasms were noted in lower lumbar region.

I feel the patient continues to be disabled from all work due to the 4/30/78 injury. If additional information is needed, please feel free to contact me.

Sincerely.

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

October 15, 1980

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

I last saw the above patient on 10/15/80. At that time she was complaining of pain and stiffness in the lower back. When she walked, her gait favored the left side more than the right.

Examination revealed limited range of motion. Muscle spasms continue to be noted and I could not, at this time, obtain a straight leg raising because of pain.

Patient to continue medication for muscle spasms and physical therapy three times a week. I also recommend no work until patient is seen for next re-check.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

November 20, 1981

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

Patient was seen 11/20/81 and continues to complain of pain and stiffness.

Physical examination noted straight leg raising of 60° and muscle spasms in lower lumbar region. A limited range of motion was also noted.

I feel patient would benefit from a whirlpool and have recommended she rent one. To remain out of work until she is rechecked in one month.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

September 25, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

The patient was in today for her monthly check-up. Complaints of pain and stiffness continue.

Examination revealed straight leg raising of 60°. No new X-rays were taken at this time. Muscle spasms continue in lower lumbar region and this puzzles me.

Due to the continuing pain, stiffness and muscle spasms in the lower lumbar region, I would like for my associate to examine this patient. Upon next monthly visit, I will have my associate evaluate. In the interim, continue same treatment plan and remain off work.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

October 29, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

The patient was in for her monthly re-check on 10/29/83. As I advised previously, I had my associate, Dr. Wood, examine her.

His findings with which I concur were limited range of motion, straight leg raising to 40°, muscle spasms and congenital spondolosithesis. Dr. Wood recommended that muscle relaxers be discontinued and hot whirlpool baths be the substituted treatment.

At this point, I feel patient continues to be disabled from all work and may eventually have to seek disability retirement.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

May 1, 1984

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Parker, Mary H.
Claim No: A25-100000

Dear Sir:

I have examined the above on this date. The patient continues to complain of pain and stiffness in the lower lumbar region.

Examination revealed straight leg raising to 60°. X-rays revealed nothing new. Muscle spasms were noted on lower lumbar region.

It is my opinion, based on the history of the injury and the current findings above, that the patient continues to be totally disabled from any type of work due to the occupational injury.

Sincerely,

T. A. Baker, M. D.

Copy to:
Norfolk Naval Shipyard

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☑ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS	✓		
LIGHT – LIFTING 10 to 20 POUNDS	✓		
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING	✓		
REACHING OR WORKING ABOVE SHOULDER	✓		
WALKING (HOURS)	✓		
STANDING (HOURS)	✓		
SITTING (HOURS)	✓		
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:	✓		
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS
Yes, patient Contenues to have muscle spasms in the lumbar region and chronic low back pain. Prognosis is fair.

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 4/30/78 TO present
PARTIAL DISABILITY FROM — TO —

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐ REGULAR WORK ☐ Undetermined

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*
N/A

16. DIAGNOSIS OF CONDITION DUE TO INJURY
Lumbosacral Spine sprain superimposed on spondylolithesis

17. DATE OF EXAMINATION 5/7/84

18. DATES OF FURTHER APPOINTMENTS, IF ANY
To recheck in one month

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Dr. T. A. Baker

20. PROFESSIONAL DEGREE
M. D

21. DATE *(Mo., day, year)*
5/10/84

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TASK BOOK
LONG TERM CASE REVIEW
PARKER CASE

From the choices below, select one of the courses of action that you would take.

a. Notify OWCP that you are willing to offer Ms. Parker a limited duty assignment. Turn to page 212, Box 3.

b. Since the medical condition has stabilized, request OWCP to do a LWEC rating. Turn to page 252, Box 2.

c. Since the current medical evidence supports a job injury disability, review the next medical report (in 6 - 12 months) for any changes in medical status. Turn to page 211, Box 4.

d. Ask OWCP to get a medical re-evaluation of Ms. Parker on the basis that one would expect comprehensive testing if the claimant has failed to respond to conservative treatment. Turn to page 253, Box 1.

From page 190

1

The disability mentioned by the doctor (bending and stooping is painful) is not clearly related to the job injury (back strain) of 1980. Given the long time to recover from the back strain and the degenerative disk condition, the disability may be unrelated to the job injury.

Return to page 190 and make another selection.

From page 191

2

Yes. This is the correct procedure. Since Ms. Williams has an accepted claim and is no longer an agency employee, only OWCP can act directly to get the needed medical evidence.

Turn to page 192 to see a sample letter to OWCP, then turn to page 193 to begin the next module.

From page 188

3

There is some medical evidence. However, to be sufficient, the evidence would have to be:

objective (not subjective)
current (not more than 6 months old)
support total disability (not partial)

Return to page 188 and choose a different answer.

From page 210

4

Although the doctor cites specific findings supporting job-related disability, there has been no explanation of why this condition has lasted 6 years. Dr. Baker reported on Sept. 1983 that she was puzzled over the lower back spasms. Some action seems called for.

Return to page 210 and try again.

From page 188

1

Correct. The evidence is not sufficient.

Now turn to page 190 for the next task.

From page 190

2

Not really. The doctor states that the patient is disabled for work, but offers no medical reason. The doctor maintains that bending and stooping are painful, but described no other disabilities. This is not total disability.

Return to page 190 and try again.

From page 210

3

As long as the treating physician declares the claimant totally disabled and there is no prevailing medical evidence to the contrary, re-employment is not an option.

Return to page 210 and select another alternative.

From page 191

4

No, since Ms. Williams is no longer an agency employee, OWCP would have to determine if and when Ms. Williams is able to return to work.

Return to page 191 for another choice.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

You have selected names from your review of the chargeback list for cases to review. You are now reviewing the following file for Lucille Donaldson who was separated from the Postal Service on December 17, 1983. Review the following pages (214 - 231) from her case file. Assume today's date is February 8, 1985. Then answer the questions at the bottom of page 232.

If you need to refer to the Resource Book, consult pages 59 - 61.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☐ Male ☑ Female	4. Social Security Number
Donaldson, Lucille	4/24/53		336-63-1117

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: Number:
5036 So. Racine Chgo Ill 60602	312 487-7719

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U.S. Postal Service North Suburban, MSC 8999 Palmer	Main floor Dock

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents Wife/Husband ☐ Children Under 18 Years Old ☐	12. Employee's Occupation
11/7/82 3:30 ☐ AM ☑ PM	11/8/82		RC

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Coming into building slipped on wet steps	lower back & hip on right side

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Lucille Donaldson
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: U.S. Postal Service

22. Bureau or Office:

23. Name and Address of Reporting Office (No., street, city, state, Zip Code): Northern Suburban, MSC 8999 Palmer

24. Regular Work Day — Begins 3:30 ☐ AM ☒ PM — Ends 12:00 ☒ AM ☐ PM

25. Number of Hours Worked Per Day: 8

26. Circle Days Paid Per Week: S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury (mo., day, year): 11/7/82 ☐ AM ☒ PM 5:30

28. Date Reporting Office Received Notice of Injury (mo., day, year): 11/7/82

29. Date and Hour Stopped Work (mo., day, year): 11-7-82

30. If Pay Has Been Terminated, Give Date (mo., day, year):

31. 45 Day Period Begins (mo., day, year): 11/8/82

32. Pay Rate When Employee Stopped Work: $ 9.02 per hrly

33. Date and Hour Employee Returned to Work (mo., day, year): Hasn't returned ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury: Lorraine Date

35. Was Employee In Performance of Duty At The Time of Injury? ☐ Yes, ☒ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

was coming into bldg

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?

☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury (mo., day, year): 11/7/82

39. Name and Address of Physician First Providing Medical Care: Anthony Maas, M.D. 5501 So. Michigan

40. Do Medical Reports Show Employee Is Disabled For Work? ☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? ☒ Yes ☐ No. If No, Furnish A Detailed Explanation. Only know what em-
ployee stated on account of form.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor: Lorraine Date

44. Title and Office Phone Number: Supv of Mails

45. Date (mo., day, year): 11/9/82

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Anthony Maas, M.D

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Donaldson, Lucille	11-7-82	RC	336-63-1117

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

fell entering work site

7. DESCRIPTION OF REGULAR WORK, INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to [illegible] POUNDS 70			✓
PULLING/PUSHING, CARRYING			✓
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)	✓		✓
SITTING (HOURS)			
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)*? ☐ YES ☐ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

Re

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

Clmt has been advised to refrain from work

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 11/1/82 TO present
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

Lumbosacral strain

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Anthony Maas, M.D

20. PROFESSIONAL DEGREE
Family Practice

21. DATE *(Mo., day, year)*
11/7/82

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U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Anthony Maas, M.D. 5507 S. Michigan Chgo. Ill 60612

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Donaldson, Lucille	11/1/82	Reg. Clerk

5. DESCRIPTION OF INJURY OR DISEASE

Clmt fell coming into Eddy emergency low back and right hip area

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Ruth Dixon	RN
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
886-5013	11/1/82

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Bureau or Office Local Address (Including Zip Code)

FORM CA–16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle) Donaldson, Mirelle

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?

fell on steps going into work

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)

☐ Yes ☒ No

17. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)? Contusion right hip and buttocks, muscle spasm lumbar

18. WHAT IS YOUR DIAGNOSIS? lumbosacral sprain

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)

☒ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☒ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ Yes ☐ No

22. SURGERY (If any, describe type)

23. DATE SURGERY PERFORMED (mo., day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE? Medication pain pills, moist heat, physical therapy

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE? unable to determine

26. DATE OF FIRST EXAMINATION (mo., day, year) 11/7/82

27. DATE(S) OF TREATMENT (mo., day, year) 11/7 11/9 11/15, 11/18 11/23 11/27

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 11/7 TO
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK
REGULAR WORK

31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.
Clmt condition has not improved will continue conservative care.

34. DO YOU SPECIALIZE? ☒ Yes ☐ No (If yes, state specialty) Family Practice

35. SIGNATURE OF PHYSICIAN Anthony Maas, MD

36. ADDRESS (Number, street, city, state, zip code) 5507 So. Michigan

37. PHYSICIAN'S SOCIAL SECURITY NUMBER -1-3153

38. DATE OF REPORT (mo., day, year) 11/28/82

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price Cost	Unit price Per	Amount $	Amount ¢
	TOTAL					

U.S. GOVERNMENT PRINTING OFFICE : 1979 O—305-989

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Anthony Maas, M.D

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Donaldson Zwelle	11-7-82	RC	336-63-1117

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

fell entering bldg

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to ~~100~~ POUNDS 70 lbs			✓
PULLING/PUSHING, CARRYING			✓
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)	✓		
SITTING (HOURS)			✓
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. Postal Service
8999 Palmer
Injury Comp Unit
Bedford Park 60103

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☐ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

severe lumbosacral strain a muscle spasm

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 11/7/82 TO present
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐ } not yet
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

possible disc involvement has not responded to conservative care provided will refer pt for an orthopedic examination

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Anthony Maas

20. PROFESSIONAL DEGREE
Family Practice

21. DATE *(Mo., day, year)*
12/28/82

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Donaldson, Imelle

2. HOME MAILING ADDRESS (Number, street, city, state, zip code): 5036 So. Racine

3. DATE AND HOUR OF INJURY (Mo., day, year): 11-7-82 3:20 ☐ AM ☒ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year): FROM 12/23 TO present

5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE YOU?
fell on steps entering work site

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
acute LS strain with right sided sciatica
bruised right hip Pt has difficulty walking

7. WHAT IS YOUR DIAGNOSIS?
acute LS strain w R sided sciatica possible HNP

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☒ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☐ YES ☐ NO
IF YES, DATE OF ADMISSION (Mo., day, year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☐ NO

11. OPERATIONS (If any, describe type): NA

12. DATE OPERATIONS PERFORMED (Mo., day, year): NA

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Conservative care, moist heat, deathermy, pain medication

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
unable to determine

15. DATE OF FIRST EXAMINATION (Mo., day, year): 12-10-83

16. DATES OF TREATMENT (Mo., day, year): 12/10 12/22, 1/5, 1/22

17. DATE OF DISCHARGE FROM TREATMENT (Mo., day, year):

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 11/7/82 TO present
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., day, year)
LIGHT WORK unDetermined
REGULAR WORK

20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.

23. SIGNATURE OF PHYSICIAN: Kirschner Clinic

24. ADDRESS (Number, street, city, state, zip code): 530 Michigan Suite 1100

25. DATE OF REPORT (Mo., day, year): 1/23/83

CA-20
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*: Donaldson Jacelle

2. Social Security Number: 336-63-1117

3. OWCP File Number *(If known)*: A10-310564

4. Is Claim Being Made For Wage Loss? ☑ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? ☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*: From: 12/23/83 Through: present

7. Has Any Pay Been Received For The Period Shown In Item 6? ☐ Yes ☐ No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)*: $ _____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☑ No If Yes, Furnish →
a. Service Number | b. Branch Of Service | c. Period Of Service *(Mo. day, year)* From: _____ Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number | b. Address of VA Office Where Claim Is Filed | c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number | b. Date Annuity Began *(Mo., day, year)* | c. Amount of Monthly Payment $ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Richard	Husband	10/6/50	✓	Same
Aaron	son	1/15/70	✓	Same

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature: Jacelle Donaldson

16. Employee's Home Mailing Address *(Include Zip Code)*: 5036 So. Racine apt 300

17. Date *(Mo., day, year)*: 01/23/83

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$ 28,500 per	$ per	$ per	$ per
Date Employee Stopped Work →	$ 28,500 per	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type 10% N.D $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☐ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$ 28,500 per yrly

27. Inclusive Dates Regular Pay Continued During Period of Disability. Do Not Include Periods of Sick or Annual Leave
From: 11-8-82 Through: 12/22/83

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$ 7,664.56

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
N/A	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
12/23/83 ☐ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 12/23/83 Through: present

32. Deductions:

	Health Benefits	Optional Insurance
a. Was Employee Enrolled On Date Pay Stopped?	☑ Yes ☐ No	☑ Yes ☐ No
b. If Yes, Furnish Code Number.	201	
c. If Yes, Give Date Through Which Deductions Were Last Made.		

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
Hasn't returned ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ _____ per _____

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Bill Fritch	Injury Comp Supv	1/25/83

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)	2. OWCP FILE NUMBER, IF KNOWN
Donaldson, Imelle	A10-362130
3. HOME MAILING ADDRESS (Include zip code)	**4. SOCIAL SECURITY NUMBER**
5036 So. Racine Chgo 60602	336-63-1117
5. DATE AND HOUR OF INJURY (Mo., day, year)	**6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year)**
11-7-82 3:20 ☐ AM ☑ PM	FROM: 2/22 THROUGH: Present
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year)	**8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED?**
4/10/83	☑ YES ☐ NO
9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK?	
☑ YES ☐ NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	**11. STATE DIAGNOSIS**
Low back strain of lumbar	Lumbar strain

12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?

Physical therapy and deep heat tx 3x wkly

13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?	14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
NO Permanent Injury	N/A
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☑ YES ☐ NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)	**16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED?** ☐ YES ☐ NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. *(i.e. limitations in stooping, bending, lifting, etc.)*	**18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.**

19. RECOMMENDATIONS AND PROGNOSIS

Pt is making progress further diagnostic studies may be warranted

20. ADDRESS (Include zip code)	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
535 So. Michigan Suite 1100	Ortho
22. SIGNATURE OF PHYSICIAN	**23. DATE OF REPORT (Mo., day, year)**
Kristian Olsen	4/10/83

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Donaldson, Thelma

2. OWCP FILE NUMBER, IF KNOWN: AD-362130

3. HOME MAILING ADDRESS (Include zip code): 5036 So. Racine Chgo. Ill 60602

4. SOCIAL SECURITY NUMBER: 336-63-1117

5. DATE AND HOUR OF INJURY (Mo., day, year): 11/7/82 3:30 ☐ AM ☒ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: 11/22 THROUGH: Present

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6.?
☐ YES ☒ NO IF YES, COMPLETE ITEM 8.

8. AMOUNT RECEIVED $ _____
DATES COVERED BY LEAVE PAY
FROM: THROUGH:

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS

N/A

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

N A

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

N/A

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO. AMOUNT OF MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

N/A

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF: Thelma Donaldson

15. DATE (Mo., day, year): 4/10/83

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $5.35 per 100
Stock Number 029-016-00022-4

Form CA-8 Revised Nov. 1974

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
May 30, 1983

To U. S. Postal Service:

I have continued to treat Ms. Lucille Donaldson conservatively. However, to date there has been no gross improvement. Ms. Donaldson continues to complain of unremitting low back pain and pain radiating to the lower extremeties making it difficult for her to ambulate any long distances without sitting down to rest. Ms. Donaldson has not been able to clean her house or tend her garden since the onset of this injury.

Exam performed today revealed extreme tenderness of the low back with significant muscle spasm while at rest. Range of motion of the lumbar spine is restricted in all directions. Ankle jerks on the right were extremely weak compared to the left. Straight leg raising was restricted to 40° on left, 35° on right. Emg study taken this day was felt suggestive of a herniated nucleous pulposes. X-rays taken revealed degenerative disc disease at L4-L5 and small spur formations throughout the vertebrae which are felt not to be of any clinical significance.

Conclusion: Ms. Donaldson continues to have a lumbrosacral sprain superimposed on degenerative disc disease which in conjunction has made the lumbrosacral strain chronic and has not to date responded to the conservative treatment I have provided. Ms. Donaldson remains totally disabled for an indefinite period of time. I hope this report is sufficient for your needs.

Sincerely,

Kischan Chan, M. D.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607
June 10, 1983

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612

Dear Dr. Chan:

Thank you for your reports concerning Ms. Lucille Donaldson. Ms. Donaldson is employed as a regular clerk at this facility, where her duties consist of various tasks which require her physical fitness. However, we do have limited duty available for our injured employees. We are enclosing the OWCP 5 form to be completed by you once you believe Ms. Donaldson is no longer totally disabled.

We appreciate your continuing assistance in this case and will await your response.

Sincerely,

Bill Fritch
Injury Compensation Specialist

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
July 24, 1983

To U. S. Postal Service:

Ms. Donaldson has been under my care for an acute lumbrosacral strain with right sided sciatica. Emg and CT scan of 7-22-83 revealed abnormal findings suggestive of a herniated disc. Ms. Donaldson continues to be symptomatic with difficulty in walking and standing. Ms. Donaldson will be admitted shortly to the Presbyterian St. Luke Hospital to have a myelogram of the lumbar spine. If the myelogram reveals a herniated disc, Ms. Donaldson will be counseled concerning the surgical procedure that will render the most favorable results as it relates to her particular medical situation.

Kischan Chan, M. D.

TASK BOOK
LONG TERM CASE REVIEW
DONALDSON CASE

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
November 15, 1983

To U. S. Postal Service:

Ms. Lucille Donaldson was hospitalized from 10/10/83 through 10/20/83 where she underwent surgery in the form of chymopapain injection to dissolve the HNP at $L5-S_1$. Ms. Donaldson will need a period of 4 to 6 mos. for recovery prior to returning to any working duties. Ms. Donaldson was examined this day by me and appears to be making steady progress. She is no longer hampered by the severe right leg pain of before but continues to be painful in the lower back. Straight leg testing is limited to 45^{o} on right and 30^{o} on left. Babinski test is negative. Left and right ankle jerks were tested and felt to be diminished. Tenderness of the right sacroiliac with continuing muscle spasm at rest. I will continue to treat Ms. Donaldson, however she will begin a course in PT 3X weekly starting next week at the Rehab Institute for the next 2 mos. I will see her again at that time.

Sincerely,

Kischan Chan, M. D.

KISCHAN CHAN, M.D.
530 Michigan Street
Suite 1100
Chicago, Ill. 60612
May 11, 1984

To U. S. Postal Service:

I am in receipt of your inquiry concerning Ms. Donaldson whom I last examined on May 8, 1984. Ms. Donaldson has gained very little relief of the lower back pain previously described. Ms. Donaldson continues to be totally disabled and it is my opinion that this disability will be permanently totally disabling. Ms. Donaldson is only able to walk short distances and must have the aid of a cane when doing any walking. She continues on Motrin 500 mg, and Tylenol III for the pain. Ms. Donaldson's prognosis for returning to work is guarded. I have referred her to the Rehab Institute for a course in pain management.

Sincerely,

Kischan Chan, M. D.

TURN THE PAGE

a. There is adequate medical evidence to justify total disability.

Yes ____ No ____

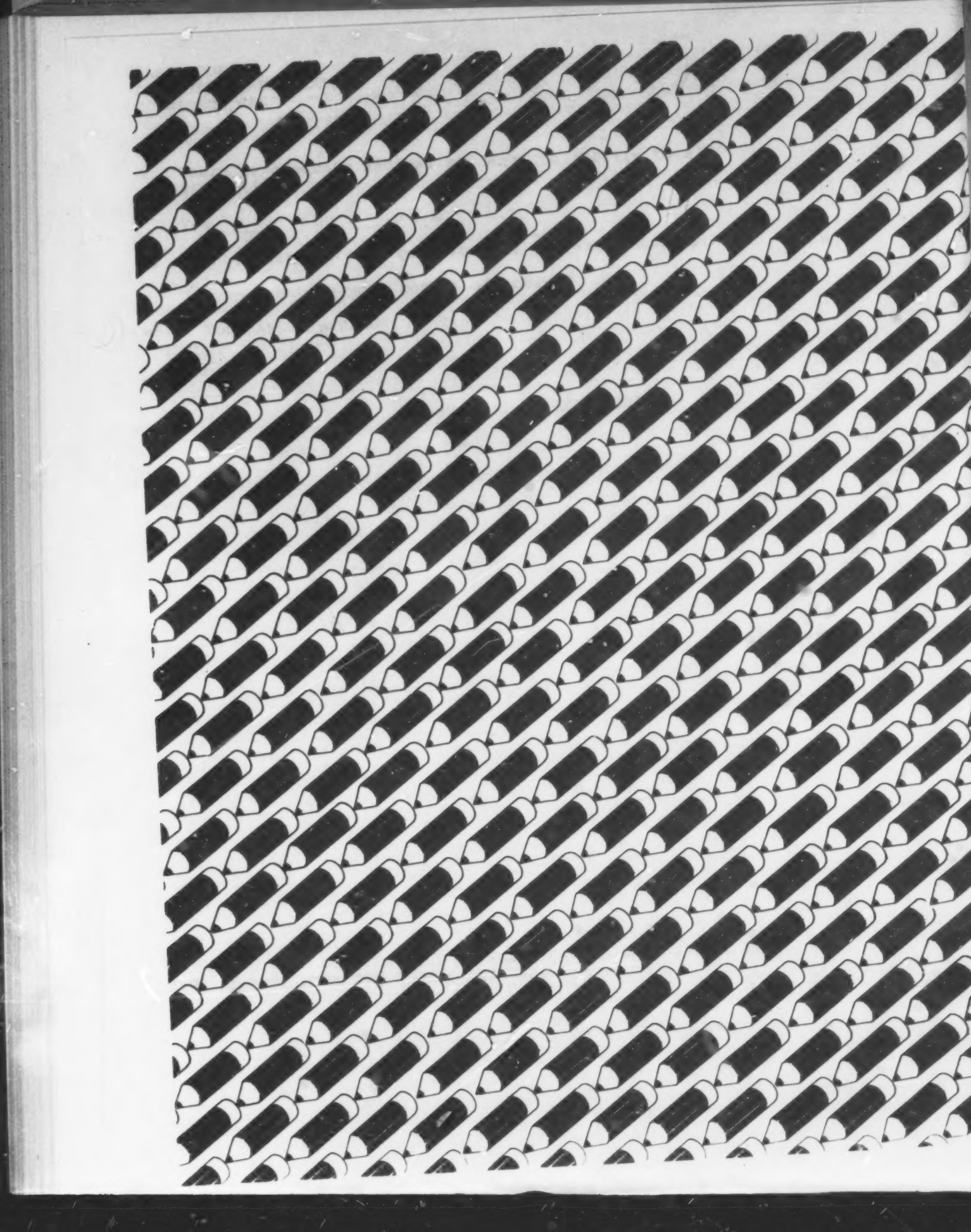
b. If no, what specific questions do you want answered?

c. If yes, what is your course of action?

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWERS TURN TO PAGE 233 TO COMPARE YOUR ANSWERS WITH THE BOOK'S ANSWERS.

CASE MATERIAL ENDS HERE



Answer:

a. No, there is not adequate medical evidence to justify total disability.

b. You would request a second opinion which would address:

1. What are the objective findings that result in her current disability?

2. To what extent are these disabilities as a result of the job related injury?

3. Is claimant totally disabled from all employment, including sedentary employment?

4. If not, what work restrictions are indicated?

c. N/A

GO ON TO THE NEXT TASK.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

Review the documents which follow (pages 235 - 243) in the file of claimant Charles M. Murphy. Then answer the questions on page 244.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Murphy, Charles M.	1-11-53	☑ Male ☐ Female	261-03-4447

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: Number:
4136 W. Congress, Chgo. Ill 60624	876-3091 312

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Chicago Main PO 433 So. Van Buren	8th floor MPO

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents: Wife/Husband ☑ Children Under 18 Years Old ☐	12. Employee's Occupation
1-7-83 ☑ AM ☐ PM 10:30	1-7-83		Clerk

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
lifting a heavy mail sack	lower back

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Charles M. Murphy
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

I Jeanette Seals was working next to Mr. Murphy when I heard him yell out I turned around and he was holding his back and told me he had injured himself

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Jeanette Seals	3334 So. Oakley	1-7-83

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: U.S.P.S. Chgo MPO

22. Bureau or Office:

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*: 433 W. Van Buren Chgo, Ill 60604

24. Regular Work Day — Begins 7:00 ☒ AM ☐ PM — Ends 3:30 ☐ AM ☒ PM

25. Number of Hours Worked Per Day: 8

26. Circle Days Paid Per Week: S (M) T W T (F) S

27. Date and Hour of Injury *(mo., day, year)*: 1-7-83 10:30 ☒ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*: 1-7-83

29. Date and Hour Stopped Work *(mo., day, year)*: 1-7-83

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*:

31. 45 Day Period Begins *(mo., day, year)*: 1-8-83

32. Pay Rate When Employee Stopped Work: $ 11.35 per hr

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury: Rae Zitzer

35. Was Employee In Performance of Duty At The Time of Injury? ☒ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*: 1-7-83

39. Name and Address of Physician First Providing Medical Care: George Perry, M.D. 8400 W. Cermak Oak Lawn, Ill 60453

40. Do Medical Reports Show Employee is Disabled For Work? ☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☒ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor: Rae Zitzer

44. Title and Office Phone Number: Supv 886-3634

45. Date *(mo., day, year)*: 1-9-83

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr. George Perry 8400 W. Airmark
Oak Lawn, Ill 60453

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Murphy, Charles M	1-7-83	Regular Mailhandler

5. DESCRIPTION OF INJURY OR DISEASE

Clmt was lifting a heavy mail sack (approx 70 lbs) when he experienced immediate pain to the lower back

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Lydia Edrazkis	RN
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
886-5000	1/7/83

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Bureau or Office Local Address (Including Zip Code)

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle) Murphy, Charles

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
Pt was lifting mail packs hurt back

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☐ Yes ☒ No

17. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
Tenderness low back

18. WHAT IS YOUR DIAGNOSIS?
Lumbosacral strain

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☒ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☒ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ Yes ☒ No

22. SURGERY (If any, describe type)

23. DATE SURGERY PERFORMED (mo., day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Hot packs, muscle relaxants

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
None anticipated

26. DATE OF FIRST EXAMINATION (mo., day, year)
1-7-83

27. DATE(S) OF TREATMENT (mo., day, year)
1-7-83, 1-14-83
1-21,

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)
Not discharged

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 1-7 TO present
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK indefinite
REGULAR WORK

31 IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS. No work until seen by Dr Gilian orthopedist appt for 4/15/83

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.
Pt advised not to perform any work until seen by ortho specialist

34. DO YOU SPECIALIZE? ☒ Yes ☐ No (If yes, state specialty) Family Medicine

35. SIGNATURE OF PHYSICIAN
Ted Perry, M.D

36. ADDRESS (Number, street, city, state, zip code)
84 W West Terrace
Cal Fallon, Al 60453

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
134 42

38. DATE OF REPORT (mo., day, year)
1-21-83

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price: Cost	Unit price: Per	Amount: $	Amount: ¢
	TOTAL					

U.S. GOVERNMENT PRINTING OFFICE : 1979 O—305-999

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

LETTER:

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

March 20, 1983

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433

Dear Dr. Gillian:

We are writing you concerning our employee, Mr. Charles M. Murphy, who was referred to you by Dr. George Perry. Mr. Murphy is a regular mailhandler. This position requires quite a bit of standing, walking, lifting, etc. However, we are able to provide Mr. Murphy with a sedentary position in keeping with any work restrictions you deem warranted. If Mr. Murphy is not totally disabled for all gainful employment, please complete the enclosed CA-17 form so we may extend Mr. Murphy a limited duty position.

Sincerely,

John E. Jacobson
Injury Compensation Unit

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
James Gillian, M.D

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Murphy Chas M	1-7-83	Rmth	261-03-4444

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
Lifting mail sacks

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS. Amt loads & unloads tractor trailers, must be able to lift up to 70 lbs

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS			✓
HEAVY – LIFTING 50 to ~~100~~ POUNDS 70 lbs			✓
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)			✓
SITTING (HOURS)			
STOOPING (HOURS)			✓
KNEELING (HOURS)			✓
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			

Light duty work in a modified position is available

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
Chicago NPO
Injury Comp Unit
433 W. Van Buren
Chgo, Ill 60607

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☒ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

will reevaluate in 4 wks

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

C/O persistent Low back pain

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 1/7/83 TO indefinite
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

C/S lumbar strain
Clnt will be attending P.T 3x weekly

17. DATE OF EXAMINATION 4/15/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Allen, M.D

20. PROFESSIONAL DEGREE
Orthopedics

21. DATE *(Mo., day, year)*
4/15/83

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TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

May 1, 1983

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433

Dear Dr. Gillian:

We are writing you concerning our employee, Mr. Charles M. Murphy, who is continuing under your care. Thank you for your latest report dated 4-15-83 in which you report Mr. Murphy is totally disabled for all gainful employment. In order for us to further clarify Mr. Murphy's medical status please answer the following questions:

1. In your opinion, are there objective findings attributable to the job injury of 1-7-83?

2. If there are objective residuals, please list them.

3. In your opinion, specifically what are the residuals which preclude Mr. Murphy from returning to a modified sedentary non-competitive position?

We appreciate your continuing assistance in this case and will await your prompt response.

Sincerely,

John E. Jacobson
Injury Compensation Unit

James Gillian, M.D.
Orthopedics, Unlimited
7600 S. Kostner
Ford City, Ill. 60433
May 15, 1983

Mr. John E. Jacobson
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

Mr. Charles Murphy continues to be totally disabled for work. He is continuing in physical therapy 2 X weekly. His improvement has and continues to be slow. Mr Murphy continues to have a painful back, and muscle spasm upon examination. Mr. Murphy reports that approximately one week ago while leaning over to tie his shoe, he was unable to straighten back up and has noticed increased pain in the lumbar area since this incident. I am giving Mr. Murphy a trial period of Darvon to help in alleviating his pain. Mr. Murphy will be reexamined in 6 weeks. At this time he remains totally disabled.

Sincerely,

James Gillian, M. D.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 1

Mr. Murphy continues on his agency's roll. Assume today's date is May 18, 1983.

What is the next step for you to take? Circle the letter of one of the courses of action below. Then turn to the page indicated.

a. Schedule a Fitness for Duty examination for Mr. Murphy. Turn to page 252, Box 4.

b. The doctor clearly states that Mr. Murphy is totally disabled. Reevaluate after his next examination in six weeks. Turn to page 253, Box 3.

c. Request OWCP to send Mr. Murphy for a second opinion. Turn to page 273, Box 1.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

You have written the following letter to Dr. McNeil requesting a Fitness for Duty examination. The results of the Fitness for Duty examination follow. Review pages 246 - 249, then answer the questions on page 250.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

U. S. POSTAL SERVICE
Chicago Main Post Office
433 West Van Buren
Chicago, Illinois 60607

June 4, 1983

Rudolph McNeil
Orthopedic Surgeon
4355 Pratt Street
Chicago, Ill 60608

Dear Dr. McNeil:

Thank you for agreeing to evaluate Mr. Charles Murphy who has an appointment with you on 6/25/83. Mr. Murphy was lifting mail sacks on 1/7/83 when he experienced immediate discomfort to his lower back. Mr. Murphy stopped work that day, not to return.

Upon completion of your exam we are requesting a narrative report of your findings and the completion of the enclosed CA-17 to illustrate what work activities, if any, Mr. Murphy can perform.

Sincerely,

John E. Jacobson
Injury Compensation Unit

best copy available

Rudolph McNeil
Orthopedic Surgeon
4355 Pratt Street
Chicago, Ill 60608
June 26, 1983

Mr. John E. Jacobson
Injury Compensation Unit
433 West Van Buren
Chicago, Illinois 60607

Dear Mr. Jacobson:

I examined Mr. Murphy in my office on 6/25/83 at which time Mr. Murphy appeared promptly for the exam. He entered the office with a brisk gait. However, upon noting my observation, his walking became slow and affected. Upon exam of the lumbar spine Mr. Murphy was extremely guarded in the range of motion exercise demonstrating no range of motion in the lumbar spine. Straight leg testing was restricted in all directions. Ankle jerks were found to be brisk and active. X-rays of the lumbar spine revealed no abnormalities. Emg, however, did suggest a higher reading in the left lower extremity, more so than on the right.

Conclusions: It is my opinion that Mr. Murphy does have a lumbrosacral strain resolving. However, this condition does not preclude him from returning to work in a limited duty status. I have completed the CA-17 form (attached) as requested. It should be noted, however, that Mr. Murphy views his disability as totally disabling and therefore it will be extremely difficult in getting him to return to any working duties. I have advised Mr. Murphy that he can return to work in a modified position and that your office says there is one available.

Thank you for having me examine this most interesting patient.

Sincerely,

Rudolph McNeil
Orthopedic Surgeon

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
Rudolph McNeil
4355 Pratt Street Chgo, Ill. 60608

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Murphy, Charles M	1-7-83	RMN	361-03-4444

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
lifting mail packs

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS
Cart loads & unloads mail packs & trays, operates tractor trailers Mail the rest of the time walking, bending, reaching

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS			✓
HEAVY – LIFTING 50 to 100 POUNDS 70 lbs			✓
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)	✓		✓
SITTING (HOURS)			
STOOPING (HOURS)			✓
KNEELING (HOURS)			✓
REPEATED BENDING (HOURS)	✓		✓
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			

Light duty work in a modified position is available

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)?* ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☑ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS	✓		
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING		✓	
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)		✓	
STANDING (HOURS)		✓	
SITTING (HOURS)			✓
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 4/25 TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*
Yes - I advised that he can return to light work

16. DIAGNOSIS OF CONDITION DUE TO INJURY No lifting over 20 lbs & no bending
resolving lumbar paraspinal strain

17. DATE OF EXAMINATION 6/25/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY None

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Rudolph "Mac" Neil

20. PROFESSIONAL DEGREE
M.D.

21. DATE *(Mo., day, year)*
6/25/83

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 2

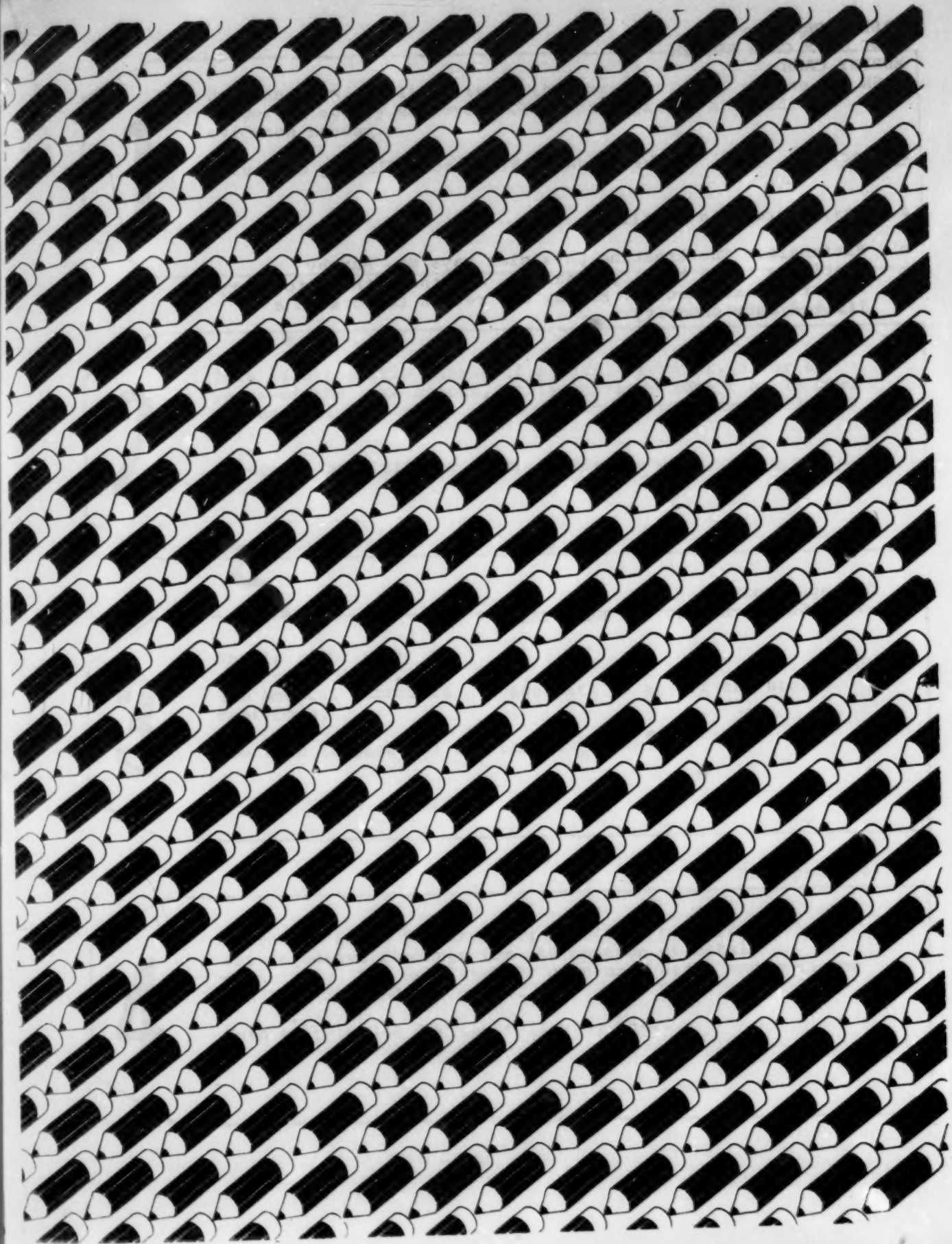
a) Is there any conflict?

b) Give your rationale.

WRITE YOUR ANSWERS BELOW.

AFTER YOU HAVE WRITTEN YOUR ANSWER, LOOK AT THE BOOK ANSWER ON PAGE 251.

TASK MATERIAL ENDS HERE



Answer:

a. Yes, there is a conflict.

b. Rationale. The treating physician says Mr. Murphy continues to be totally disabled, and the Fitness for Duty report states that Mr. Murphy can return to work in a limited duty capacity.

TURN TO PAGE 254 AND DO THE NEXT TASK.

From page 190

1

No. Since Ms. Williams is on the periodic roll, and no longer an agency employee, OWCP would gather any medical evidence needed.

Return to page 190 for a different choice.

From page 210

2

This is a possible course of action. However, after 6 years of the same status, it is unlikely that 6 or 12 more months will help much. More direct action seems called for.

Return to page 210 for another selection.

From page 190

3

That's right.

The medical report is not adequate in any of the areas mentioned.

Now turn to page 191 for the next task.

From page 244

4

Correct. Since the treating physician has not provided any objective findings for his opinion of total disability, you need another opinion. As an employee, he can be scheduled for a FFD.

Turn to page 245 for the following task.

From page 210

1

That is correct. After this length of time (6 years) the doctor should be asked why a full range of diagnostic tests hasn't been considered.

Now turn to page 213 to begin the next case.

From page 191

2

No. Since Ms. Williams is no longer an agency employee, you cannot order a Fitness for Duty exam.

Return to page 191 and choose again.

From page 244

3

Not quite. The doctor certainly claims total disability. However, in response to your direct request for objective findings and specific residuals which prevent working, he did not respond adequately. He only pointed out subjective findings of pain. You may have to get the information elsewhere.

Return to page 244 and try again.

From page 190

4

Not really. The doctor does indicate that the patient is suffering from back strain, degenerative disk and diabetes. But the reasons cited for disability are subjective, that is, the patient's complaints of pain. This does not meet the criteria of objective findings.

Return to page 190 for another choice.

What steps would you take to resolve the conflict? Circle the letter below of the answer you select. Then turn to the page listed next to your answer.

a. Although the treating physician claimed total disability, it was based on only the patient's subjective pain. On the other hand, the FFD report shows objective findings, so you may use the FFD and assign Mr. Murphy to light duty. Turn to page 301, Box 3.

b. There is a clear conflict of medical opinion and you would have to write OWCP, enclosing the medical reports and requesting an impartial medical evaluation. Turn to page 273, Box 2.

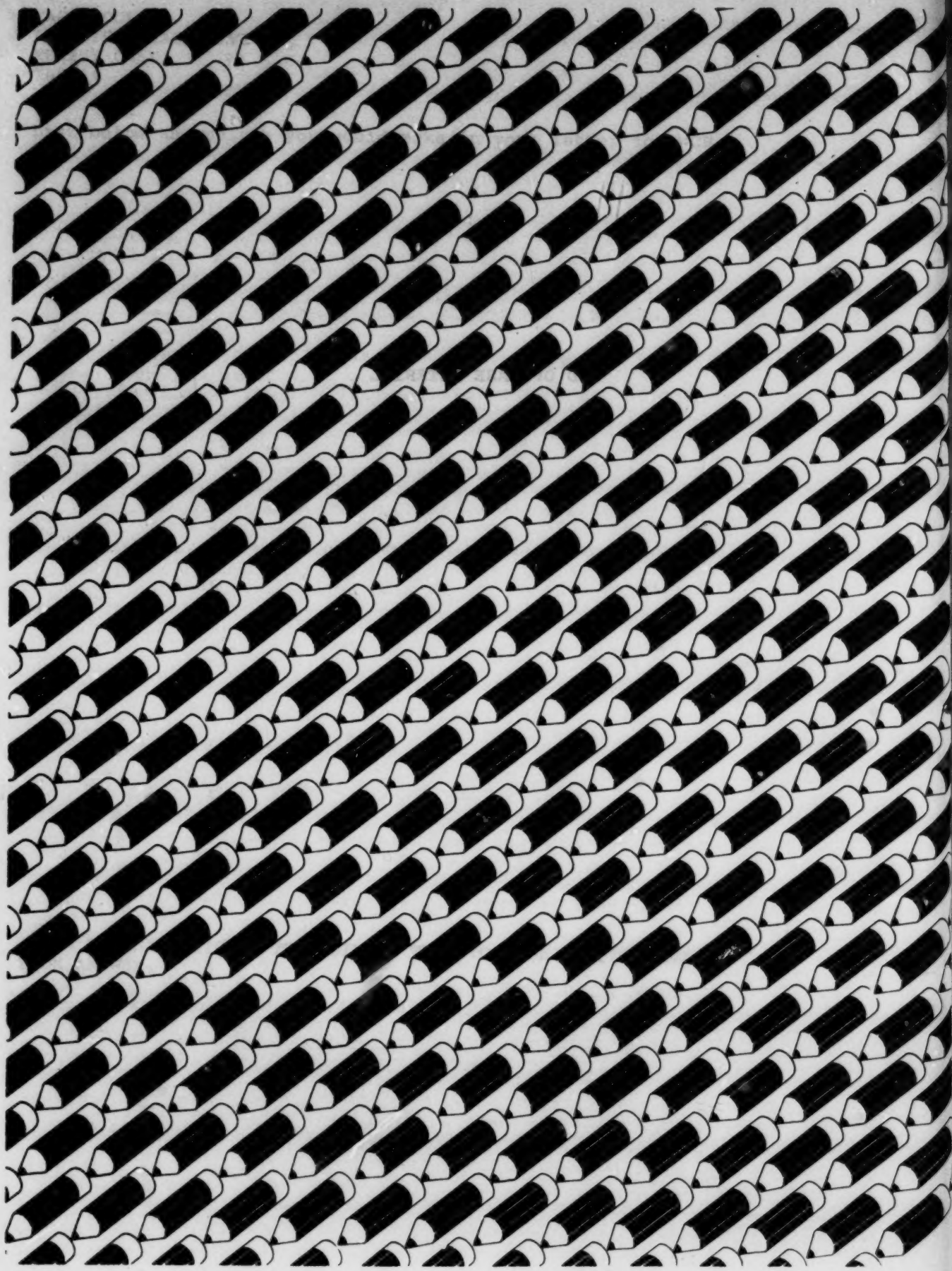
c. Since there is some conflict, you can require the claimant to go to a third doctor whose opinion will resolve the problem. Turn to page 300, Box 1.

TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 4

List below the points you would make in your letter to OWCP.

AFTER YOU HAVE LISTED THE POINTS, TURN TO PAGE 256 TO READ THE BOOK ANSWER.

END OF CASE MATERIAL



TASK BOOK
LONG TERM CASE REVIEW
MURPHY CASE
TASK 4

Answer:

1. Claimant Charles Murphy has continued under treatment of Dr. James Gillian who has provided conservative care through the present.

2. Dr. Gillian has continued to support total disability from the date of injury through the present.

3. Mr. Murphy was sent for a Fitness for Duty exam performed by Ortho Rudolph McNeil (report enclosed). Dr. McNeil reports that Mr. Murphy is not totally disabled for all gainful employment and that he could return to work in a limited duty position illustrated in the enclosed CA-17.

4. Mr. Murphy was informed by Dr. McNeil that he can return to work in a limited duty position and that there is a modified position available.

5. We are requesting a full review of this case and that the medical conflict which now exists be resolved by an impartial medical examination to be scheduled by OWCP.

TURN THE PAGE TO BEGIN A NEW MODULE.

REHABILITATION

As in the previous modules, you will be given a case and a series of tasks. For the tasks in this module you will be asked to:

a. Make an initial decision about the case on the basis of the information given, and

b. Decide what action you will take to resolve the case.

TURN THE PAGE TO BEGIN THE MODULE ON REHABILITATION.

TASK BOOK
REHABILITATION
PERRY CASE
TASK 1

No new resource material is required for this first task. If you wish to refer back to the Resource Book, consult pages 58 - 63.

Review the case file for Mr. Bill Perry on pages 259 - 271. Then turn to page 272 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3.	4. Social Security Number
Perry, Bill W.	9/20/40	☑ Male ☐ Female	223-42-3514

5. Employee's Home Mailing Address (No., street, city, state, zip code)
102 Lilac Ave
Norfolk, Va 23709

6. Home Telephone
Area Code: 804
Number: 587-1057

7. Name and Address of Employing Agency
Norfolk Naval Shipyard
Industrial Relations Office
Portsmouth, Va 23709

8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
machine shop
Bldg 171

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
5/10/79 ☑ AM ☐ PM 8:30	5/10/79	Wife/Husband ☑ Children Under 18 Years Old ☑	machinist

13. Cause of Injury (Describe how and why the injury occurred)
I was working on the conveyor belt when it was switched on and caught my right arm & hand.

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Right Arm & Hand (Laceration & Strain)

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Bill W. Perry
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
NAVY

22. Bureau or Office
Norfolk Naval Shipyard

23. Name and Address of Reporting Office (No., street, city, state, Zip Code)
Norfolk Naval Shipyard, Industrial Relations Office, Portsmouth, Va 23709

24. Regular Work Day
Begins 7:30 ☐ AM ☐ PM
Ends 4:00 ☐ AM ☑ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury (mo., day, year)
5/10/79 8:30 ☐ AM ☐ PM

28. Date Reporting Office Received Notice of Injury (mo., day, year)
5/10/79

29. Date and Hour Stopped Work (mo., day, year)
5/10/79

30. If Pay Has Been Terminated, Give Date (mo., day, year)

31. 45 Day Period Begins (mo., day, year)
5/11/79

32. Pay Rate When Employee Stopped Work
$ 10.00 per hour

33. Date and Hour Employee Returned to Work (mo., day, year)
Still out ☐ AM ☐ PM

34. Name of Supervisor At Time of Injury

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury (mo., day, year)
5/10/79

39. Name and Address of Physician First Providing Medical Care
Dr. Douglas Fairbanks
203 Medical Towers
Norfolk, Va 23709

40. Do Medical Reports Show Employee is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Billy L. Gallup

44. Title and Office Phone Number
Head, Employee Services
(821) 396-7586 DSN

45. Date (mo., day, year)
5/15/79

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr. Douglas Fairbanks
203 Medical Towers
Norfolk, Va 23709

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Perry, Bill W.	5/10/79	machinist

5. DESCRIPTION OF INJURY OR DISEASE

"Was working on the conveyor belt when it was switched on and caught my right arm and hand."

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE

10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	11. DATE (mo., day, year)
(804) 396-7886	5/10/79

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Navy Bureau or Office Norfolk Naval Shipyard Local Address (Including Zip Code) Portsmouth Va 23709

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
Perry, Bill W.

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
Injured right arm and hand in conveyor belt.

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☐ Yes ☑ No

17. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
swelling, plagerism of right hand

18. WHAT IS YOUR DIAGNOSIS?
Sprain arm, right
Laceration right hand

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☑ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☑ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED?
☐ Yes ☑ No

22. SURGERY (If any, describe type)
Stitches to close laceration

23. DATE SURGERY PERFORMED (mo., day, year)
5/10/79

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
medication for pain, physical therapy

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unknown

26. DATE OF FIRST EXAMINATION (mo., day, year)
5/10/79

27. DATE(S) OF TREATMENT (mo., day, year)

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)
—

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 5/10/79 TO Continuing
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK N/A
REGULAR WORK

31 IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.

34. DO YOU SPECIALIZE? ☑ Yes ☐ No (If yes, state specialty) Orthopedics

35. SIGNATURE OF PHYSICIAN
Douglas Fontanella

36. ADDRESS (Number, street, city, state, zip code)
203 Medical Towers
Norfolk, Va 23709

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
031-03-3333

38. DATE OF REPORT (mo., day, year)
5/12/79

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price Cost	Unit price Per	Amount $	Amount ¢
5/10/79	Initial Exam	1	150	00	150	00
	TOTAL					

U.S. GOVERNMENT PRINTING OFFICE : 1979 O—320-880

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee (Last, first, middle): Penny, Bud W.

2. Social Security Number: 223-42-3514

3. OWCP File Number (If known): A25-505142

4. Is Claim Being Made For Wage Loss? ☑ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? ☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss (Mo., day, year)
From: 6/27/74 Through: Continuing

7. Has Any Pay Been Received For The Period Shown In Item 6? ☐ Yes ☑ No If Yes, State Full Amount And Inclusive Dates For Such Period (Mo., day, year)
$ _____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☑ No If Yes, Furnish →
a. Service Number
b. Branch Of Service
c. Period Of Service (Mo. day, year)
From: _____
Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number
b. Address of VA Office Where Claim Is Filed
c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number
b. Date Annuity Began (Mo., day, year)
c. Amount of Monthly Payment
$ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? (Yes/No)	Mailing Address, If Different From Your Own
Nora K.	Spouse	4/23/43	Yes	

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature: Bud W. Penny

16. Employee's Home Mailing Address (Include Zip Code)
1021 Tac Ave
Norfolk, Va 23509

17. Date (Mo., day, year): 6/27/74

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*
Norfolk Naval Shipyard, Industrial Relations, Portsmouth, Va 23709

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$ 10.00 per hour	$ per	$ per	$ per
Date Employee Stopped Work →	$ 10.00 per hour	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type N/A $ per

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury? ☑ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury? ☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service
6 Yrs

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$ 10.00 per hour

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave
From: 5/11/79 Through: 6/26/79

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*

a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
6/27/79 4:00 ☐ AM ☑ PM

31. Period For Which Compensation Is Claimed
From: 6/27/79 Through: Continuing

32. Deductions:
a. Was Employee Enrolled On Date Pay Stopped? Health Benefits ☑ Yes ☐ No; Optional Insurance ☐ Yes ☑ No
b. If Yes, Furnish Code Number. 102
c. If Yes, Give Date Through Which Deductions Were Last Made.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
Still Out ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ per

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Billy Galley	Head, Employee Services (804) 396-5888 Div	6/28/79

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle) Perry, Bill W.	2. OWCP FILE NUMBER, IF KNOWN A25-505142
3. HOME MAILING ADDRESS (Include zip code) 102 Tilge Ave Norfolk, Va 23709	4. SOCIAL SECURITY NUMBER 223-42-3514
5. DATE AND HOUR OF INJURY (Mo., day, year) 5/10/79 8:30 ☒ AM ☐ PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) FROM: 8/1/79 THROUGH: Continuing
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year) 7/31/79	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? ☒ YES ☐ NO
9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? ☒ YES ☐ NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT Sprain Right Arm with Possible tendon + nerve damage, healing location	11. STATE DIAGNOSIS Same as item 10
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN? Re-evaluation monthly	
13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED? Unknown	14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY Arthritis, left foot Persistent obesity Past femoral iliac bypass
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☒ YES ☐ NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)	16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? ☐ YES ☒ NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)	18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.
19. RECOMMENDATIONS AND PROGNOSIS	
20. ADDRESS (Include zip code)	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
22. SIGNATURE OF PHYSICIAN Dr. Douglas Fairbanks	23. DATE OF REPORT (Mo., day, year) 7/31/79

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*	2. OWCP FILE NUMBER, IF KNOWN
Perry, Bill W.	A25-505142
3. HOME MAILING ADDRESS *(Include zip code)*	**4. SOCIAL SECURITY NUMBER**
102 Ridge Ave Norfolk, Va 23709	223-42-3514
5. DATE AND HOUR OF INJURY *(Mo., day, year)* 5/10/79 8:30 ☑ AM ☐ PM	**6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS** *(Mo., day, year)* FROM: 8/1/79 THROUGH: Continuing
7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6.? ☐ YES ☑ NO IF YES, COMPLETE ITEM 8.	**8. AMOUNT RECEIVED $** _____ **DATES COVERED BY LEAVE PAY** FROM: THROUGH:

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER
		N/A		

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO.	DATE OF REGISTRATION	OFFICE ADDRESS
	N/A	

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

N/A

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO.	NATURE OF DISABILITY AND MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
	N/A	

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO.	AMOUNT OF MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
	N/A	

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF	15. DATE *(Mo., day, year)*
Bill W. Perry	8/1/79

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $5.35 per 100
Stock Number 029-016-00022-4

Form CA-8 Revised Nov. 1974

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)* Still Out ☐ AM ☐ PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY

S	M	T	W	T	F	S

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6. ON THE REVERSE SIDE?

☐ YES ☒ NO

19. IF ANSWER TO ITEM 18. IS YES, SHOW:

AMOUNT: $

TYPE OF PAYMENT:

PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(Mo., day, year)*
Bicky Gallup	Head, Employee Services Div	8/1/79

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1. through 15. on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16. through 24. and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1. through 6. on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3. on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.

Form CA-8 Revised Nov. 1974

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Perry, Bill W.

2. HOME MAILING ADDRESS (Number, Street, City, State, Zip Code): 102 Tibbe Ave. Norfolk, Va 23709

3. DATE AND HOUR OF INJURY (Mo., Day, Year): 5/10/79 8.30 ☑ AM ☐ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., Day, Year): FROM 5/10/79 TO Continuing

5. WHAT HISTORY OF INJURY (Including disease caused by the employment) DID EMPLOYEE GIVE YOU?
Injured rt arm and hand in a conveyor belt

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
Spiral right ulna with possible tendon + nerve damage, Deat Leather location

7. WHAT IS YOUR DIAGNOSIS?
Same as above

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☑ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☐ YES. ☑ NO

IF YES, DATE OF ADMISSION (Mo., Day, Year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☑ NO

11. OPERATIONS (If any, describe type): Closed reduction

12. DATE OPERATIONS PERFORMED (Mo., Day, Year): 5/10/79

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unknown

15. DATE OF FIRST EXAMINATION (Mo., Day, Year): 5/10/79

16. DATES OF TREATMENT (Mo., Day, Year)

17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year): N/A

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 5/10/79 TO Continuing
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., Day, Year)
LIGHT WORK
REGULAR WORK

20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK. ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.

23. SIGNATURE OF PHYSICIAN: Douglas Turlands

24. ADDRESS (Number, Street, City, State, Zip Code): 203 Medical Towers Norfolk Va 23709

25. DATE OF REPORT (Mo., Day, Year): 7/5/80

CA-20
(REV. AUG. 1976)

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)
Tony Bell W

2. OWCP FILE NUMBER, IF KNOWN
A25-505142

3. HOME MAILING ADDRESS (Include zip code)
102 Lilac Ave
Norfolk Va 23509

4. SOCIAL SECURITY NUMBER
223-42-3514

5. DATE AND HOUR OF INJURY (Mo., day, year)
5/10/79 8:30 ☑ AM ☐ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year)
FROM: 5/10/79 THROUGH: Present

7. DATE OF MOST RECENT EXAMINATION (Mo., day, year)
10/21/81

8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED?
☑ YES ☐ NO

9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK?
☑ YES ☐ NO

10. DESCRIBE NATURE OF PRESENT IMPAIRMENT
Sprain - Lt Arm with possible tendon + nerve damage

11. STATE DIAGNOSIS
Same as item 10

12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?
Medication, ointment

13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?
Unknown

14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
Arthritis left leg, chronic back pain, undetermined post pregnant heat typhus

15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☑ YES ☐ NO
IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)

16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? ☐ YES ☑ NO
IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)

17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)
N/A

18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.

19. RECOMMENDATIONS AND PROGNOSIS
Prognosis guarded

20. ADDRESS (Include zip code)

21. IF YOU SPECIALIZE, INDICATE SPECIALTY
Orthopedics

22. SIGNATURE OF PHYSICIAN
Douglas Fairbanks

23. DATE OF REPORT (Mo., day, year)
10/25/81

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)	2. OWCP FILE NUMBER, IF KNOWN
Young, Bill W.	A25-505142
3. HOME MAILING ADDRESS (Include zip code)	**4. SOCIAL SECURITY NUMBER**
102 Tulane Ave Norfolk Va 23509	223-42-3514

5. DATE AND HOUR OF INJURY (Mo., day, year)	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year)
5/10/79 8:30 ☑ AM ☐ PM	FROM: 5/10/79 THROUGH: Present

7. DATE OF MOST RECENT EXAMINATION (Mo., day, year)	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED?	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK?
12/5/82	☑ YES ☐ NO	☑ YES ☐ NO

10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	11. STATE DIAGNOSIS
Sprain - R Arm with traumatic arthritis	Same as Item 10

12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?

Medication and Therapy

13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?	14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
—	Obesity, Chronic ~~Pain~~ back Pain, Chronic renal failure, hypertension, Chronic venous stasis, both Legs
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☑ YES ☐ NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)	**16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? ☐ YES ☑ NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)**
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. limitations in stooping, bending, lifting, etc.)	**18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.**
—	—

19. RECOMMENDATIONS AND PROGNOSIS

Prognosis Guarded

20. ADDRESS (Include zip code)	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
22. SIGNATURE OF PHYSICIAN	**23. DATE OF REPORT (Mo., day, year)**
Douglas Fairbanks	12/5/82

Form CA-20a Revised Nov. 1974

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

FOR INSTRUCTIONS SEE REVERSE SIDE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)	2. OWCP FILE NUMBER, IF KNOWN
Perry, Bill D.	A25-505142
3. HOME MAILING ADDRESS (Include zip code)	**4. SOCIAL SECURITY NUMBER**
102 Tyler Ave Norfolk, Va 23509	223-42-3514
5. DATE AND HOUR OF INJURY (Mo., day, year)	**6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year)**
5/10/79 8:30 ☑ AM ☐ PM	FROM: 5/10/79 THROUGH Present
7. DATE OF MOST RECENT EXAMINATION (Mo., day, year)	**8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED?**
9/25/83	☑ YES ☐ NO
9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK?	
☐ YES ☑ NO	

10. DESCRIBE NATURE OF PRESENT IMPAIRMENT
1) Obesity 2) Chronic back pain 3) chronic renal failure, hypertension 4) chronic venous stasis, both legs

11. STATE DIAGNOSIS
5) Arm Sprain, right, resolving
Same as 10

12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?
Medication, exercises, medical re-evaluation

13. WHAT PERMANENT EFFECTS, IF ANY, ARE ANTICIPATED?
None

14. DESCRIBE ANY CONCURRENT DISABILITY EMPLOYEE HAS WHICH IS NOT RELATED TO THIS INJURY
1) Obesity 2) Chronic back pain 3) chronic renal failure, hypertension 4) chronic venous stasis, both legs

15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? ☐ YES ☑ NO
IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (Mo., day, year)

16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN SO ADVISED? ☐ YES ☑ NO
IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)

17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. *(i.e. limitations in stooping, bending, lifting, etc.)*
Can resume light duty

18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.

19. RECOMMENDATIONS AND PROGNOSIS

20. ADDRESS (Include zip code)	21. IF YOU SPECIALIZE, INDICATE SPECIALTY
	Endocrinology
22. SIGNATURE OF PHYSICIAN	**23. DATE OF REPORT (Mo., day, year)**
Douglas Fairbanks, MD	9/25/83

Form CA-20a Revised Nov. 1974

TASK BOOK
REHABILITATION
PERRY CASE
TASK 1

Assume today's date is January 14, 1984. Mr. Perry is no longer on the agency's rolls. If you wish to refer to the Resource, consult pages 58 - 63.

Why is there reason to question compensation for disability? Circle the letter below of the best answer.

a. There is inadequate medical justification for total disability. Turn to page 300, Box 2.

b. The claimant's current disability may be unrelated to the job injury. Turn to page 301, Box 2.

c. The claimant is now able to do light duty work. Turn to page 329, Box 4.

d. There is a concurrent condition that accounts for his present disability. Turn to page 326, Box 1.

From page 244

1

Since you have not been able to get objective-findings, you do need another source. However this isn't the most direct way.

Return to page 244 for an alternative.

From page 254

2

That is correct. The conflict is clear and only OWCP can resolve it.

Turn to page 255 for the next task.

From page 190

3

No. The medical report dated 3/14/81 is over two years old as of Dec. 4, 1983. A medical report more than 6 months old should not be used to justify disability.

Return to page 190 for another choice.

4

TASK BOOK
REHABILITATION
PERRY CASE
TASK 2

Read pages 64 - 71 in the Resource.

What steps would you take now? Select one of those listed below.

a. Schedule a Fitness for Duty exam for Mr. Perry and with the work limitations obtained, design a light duty job. Turn to page 326, Box 3.

b. Request that OWCP get work restrictions from the attending physician and modify a job to accommodate them. Turn to page 301, Box 1.

c. Ask OWCP to have the attending physician identify restrictions due to occupational injury and modify a job to meet them. Turn to page 327, Box 3.

d. Have OWCP get from the doctor, work restrictions resulting from pre-existing conditions and job related injury and design a light duty job to suit them. Turn to page 300, Box 4.

TASK BOOK
REHABILITATION
PERRY CASE
TASK 3

Read pages 72 - 75 in the Resource.

Read the Form OWCP 5 which follows on page 276. Then go to page 277 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name *(First, middle, last)*: Perry, Bill W

2. OWCP No.: A25-505142

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. *Sitting*	✓						✓				✓
b. *Walking*		✓				✓					
c. *Lifting*		✓			✓						
d. *Bending*		✓		✓							
e. *Squatting*		✓		✓							
f. *Climbing*		✓		✓							
g. *Kneeling*		✓		✓							
h. *Twisting*		✓			✓						
i. *Standing*		✓					✓				

4. Check the lifting restriction.
☐ 0–10 lbs. ☑ 10–20 lbs. ☐ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☑ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☐ Yes ☑ No

5c. Pushing and pulling? ☑ Yes ☐ No

5d. Fine manipulation? ☑ Yes ☐ No

6. Can the worker reach or work above the shoulder? ☑ Yes ☐ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☑ Yes ☐ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☑ Yes ☐ No

9. Are there cardiac, visual, or hearing limitations?
☑ No ☐ Yes – *(Describe)*

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases? ☐ No ☑ Yes – *(Describe)* No exposure to extreme cold, dangerous

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☐ No ☑ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☑ Yes ☐ No – *(Indicate when)*

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☐ Yes ☑ No

14. Has the worker reached maximum improvement?
☑ Yes *(Indicate when)* 2/15/84 ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)*
The above restrictions are all occupational

16. Name: Douglas Fairbanks M.D.

17. Signature:

18. Address:

19. Telephone No.:

20. Date: 2/15/84

Copy Distribution: WHITE – Carrier/Employer YELLOW – OWCP Case File PINK – OWCP Rehab. File

SPO 661 888

Form OWCP-5
Sept. 1978

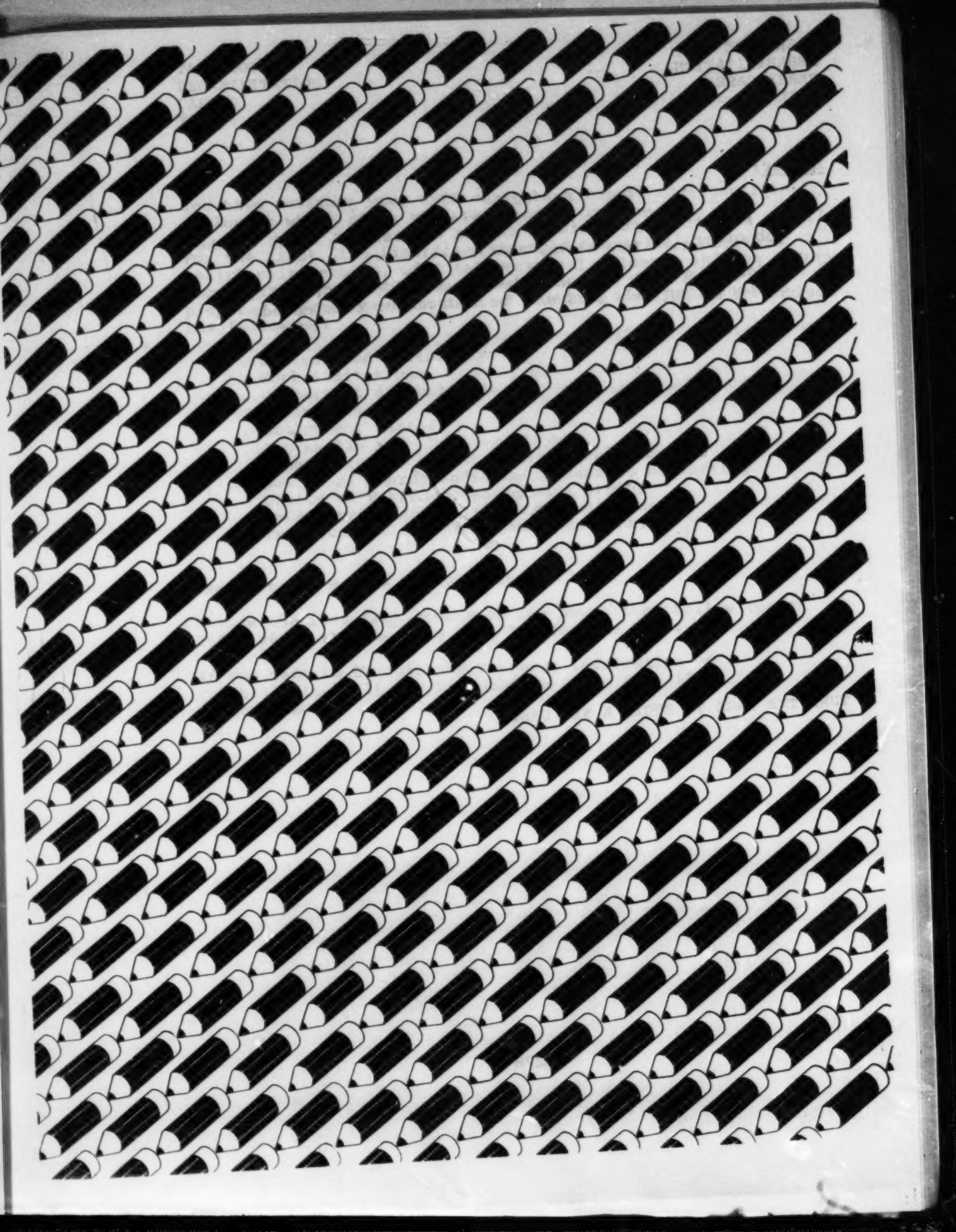
TASK BOOK
REHABILITATION
PERRY CASE
TASK 3

Taking into consideration work experience, education, physical and environmental factors and work restrictions, you have now identified a light duty assignment for Mr. Perry so he can return to gainful employment.

You are now going to make a job offer to the employee. You will have him come in to meet with you. After you have presented him with a formal written job offer, he informs you that he refuses to accept reemployment. What steps will you take with the claimant? Write your answers below.

AFTER YOU WRITE YOUR ANSWER, TURN TO PAGE 278 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

CASE MATERIAL ENDS HERE



Answer:

1. Be sure that the claimant checks the refusal block on the job offer letter and signs it.

2. Inform him that this will be forwarded to OWCP and his compensation will probably be reduced or terminated.

TURN THE PAGE TO BEGIN A NEW CASE.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

You have reviewed your OWCP chargeback report and identified employees whose files you are going to review.

For the first five identified candidates you have obtained health unit records, official personnel folders, and the injury compensation claim files. After reviewing the records you prepared a fact sheet on each of the five candidates to include the following:

- Job related disability
- Work limitations
- Concurrent disabilities
- Current age
- Employment history
- Job skills
- Length of time absent from work environment
- Number of hours candidate is capable of working
- Office of Personnel Management status
- OWCP payroll status (LWEC or full benefit)
- Previous limited duty accommodations.

Assume today's date is November 14, 1984.

Review the five fact sheets on the pages that follow (pages 280 - 284), then turn to page 285 for the task.

If you want to consult the resource information on rehabilitation, it may be found on pages 64 - 69 of the Resource Book.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Mary R. Rubin Current Age: 66 years old

Monthly pay rate - $1095.00

Date of Injury: 3/7/72. Compressed fractures of both knees as a result of a fall. Received Scheduled Award from OWCP for 60% permanent disability to both knees. Medical report dated 12/5/83 states employee could work four hours per day only in a completely sedentary assignment. Concurrent disabilities include hypertension.

Employment History: Ms. Rubin was a letter carrier for 32 years prior to her injury. There is no record of any disciplinary action in her personnel record. Did not return to work with the Postal Service after her injury. Retired on disability through OPM 6/11/74.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Joseph S. Watson Current Age: 54 years old

Monthly pay rate - $1500.00

Date of Injury: 4/10/75. Ruptured disc as a result of lifting. Has had two lumbar laminectomies and a spinal fusion. Latest medical report from orthopedist Jerry Q. Pence, M.D. dated 4/5/83 states employee is permanently disabled for any type of work. Impartial Medical Evaluation has concurred and shown poor prognosis for ever returning to work. No concurrent disabilities.

Employment History: Mr. Watson worked for the Post Office as a Distribution Clerk for 25 years prior to his injury. No disciplinary action in his personnel records and he was the recipient of a Special Achievement Award. He never returned to any gainful USPS employment after the injury and eventually secured an approved disability retirement through OPM on 11/18/76.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Alexander P. Hawkins Current Age: 46 years old

Monthly pay rate - $1150.00

Date of Injury: 8/5/78. Amputation of the right arm. Medical records dated 6/10/81 state employee is fit for limited duty eight hours per day. Only restrictions are in the area of lifting and climbing. Concurrent disabilities include multiple sclerosis diagnosed 9/15/83. Claimant is wheel-chair bound.

Employment History: Mr. Hawkins was a maintenance mechanic for seven years before his right arm was amputated in a conveyor belt accident. He was an excellent employee, the recipient of several adopted suggestion awards. He did not return to work after his injury and retired on disability through OPM on 3/9/80. Employee has AA degree in business administration.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

Alice M. Washington Current Age: 33 years old

Monthly pay rate - $1100.00

Date of Injury: 7/3/79. Ruptured lumbar disc. Refuses surgery. Medical report dated 1/9/84 states employee fit for limited duty eight hours per day. Can do no lifting, bending, squatting, climbing, kneeling or twisting. Generally needs sedentary work. No concurrent disabilities.

Employment History: Ms. Washington was hired as a Letter Carrier on 12/30/78. She was injured six months later and remained off work for approximately nine months. She returned to limited duty in 4/80 and worked in the assignment until it was terminated on 3/81. She was separated from the Postal Service in 3/82 due to her inability to perform the duties of Letter Carrier As a result of physical disability, Ms. Washington was not eligible for disability retirement because she did not have 5 years Civil Service. Has a high school diploma and was a clerk typist for an insurance company for six years prior to her Postal Service employment.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

FACT SHEET

William I. Elliott Current Age: 41 years old

Monthly pay rate - $1300.00

Date of Injury: 9/10/78 - Ruptured lumbar disc as a result of a motor vehicle accident. Has had lumbar laminectomy and fusion. Can work eight hours per day in a completely sedentary assignment with no lifting. Cannot operate a motor vehicle. No concurrent disabilities.

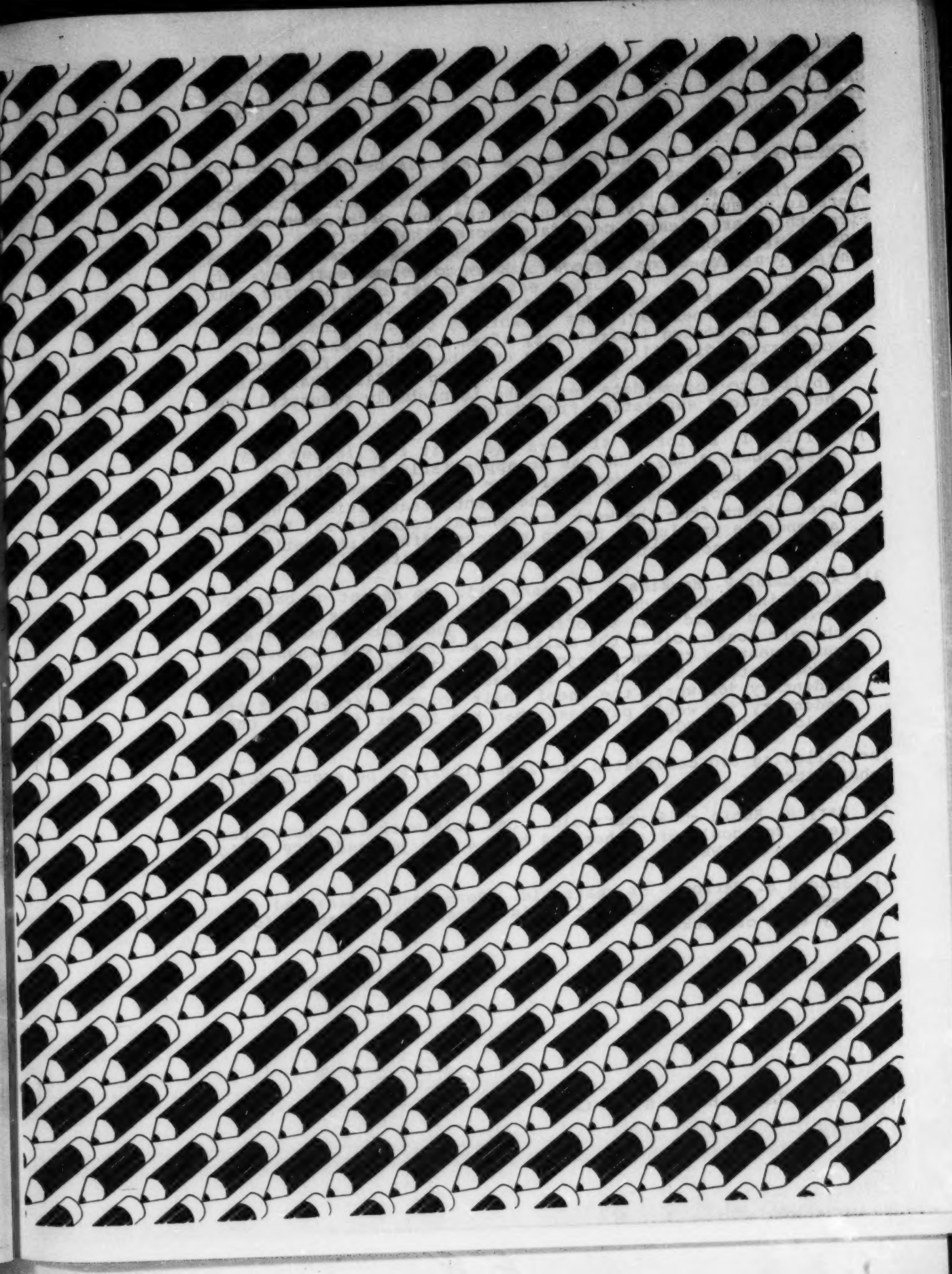
Employment History: Mr. Elliott was a tractor trailer operator for nine years prior to his injury. Had attendance problems in the past with a suspension for two weeks. Has a high school diploma. Never returned to work after the injury. Retired on an approved disability through OPM on 2/5/80.

TASK BOOK
REHABILITATION
CASE 2
TASK 1

Of the candidates whose records you have just reviewed, rank order them starting with #1 as the candidate most likely to result in a successful rehabilitation effort. Provide your rationale for each of your rankings. Write your answer below.

WHEN FINISHED, TURN TO PAGE 286 TO READ THE BOOK ANSWER.

END OF TASK MATERIAL



TASK BOOK
REHABILITATION
CASE 2
TASK 1

Answer:

There is no quantitative reason for the rank order, but the first three are clearly candidates more likely to be successfully rehabilitated. Consider your answer correct, as long as you have these three as likely to be successful:

1) Alice M. Washington - 33 years old. Fit for limited duty eight hours per day. Her disability can be accommodated since she worked limited duty after injury. She has no concurrent disabilities. Has only been absent from work environment for two years. Her typing skills enhance the ability to accommodate her. She is probably resentful over her previous separation from USPS.

2)* William I. Elliott - 41 years old. Fit for limited duty eight hours a day. He has no appreciable reemployment skills. He was a tractor-trailer operator and cannot drive a vehicle now. He has no concurrent disabilities. He has been absent from the work environment four years. Had some attendance problems. Has an approved disability retirement. Did not perform any limited duty after injury.

3)* Alexander P. Hawkins - 46 years old. He cannot go back to his maintenance mechanic job because of the loss of his arm. You would have to offer him a job that accommodates the arm loss. Since the multiple sclerosis was diagnosed subsequent to the on-the-job injury, it does not have to be accommodated. However, it is possible for him to do a sedentary job where the wheel chair doesn't matter. If the sedentary job would pay less than his former job, then OWCP would do an LWEC.

The following two candidates are less likely to be successfully rehabilitated:

4) Mary R. Rubin - 66 years old. Can only work four hours per day. You could offer her a 4 hour a day job and OWCP would then do an LWEC.

5) Joseph S. Watson - 54 years old. Permanently disabled. Medical report states that he is permanently disabled for any type of work.

TURN THE PAGE TO BEGIN A NEW CASE.

TASK BOOK
REHABILITATION
CASE 2
TASK 2

You have selected Alice M. Washington as your most viable rehabilitation candidate. You have a Work Restriction Evaluation from her treating physician and three possible job assignments.

Review the Work Restriction Evaluation from Dr. Alexander and the three job descriptions which follow on pages 288 - 291. Then turn to page 292 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name *(First, middle, last)*: Alice M Washington

2. OWCP No.: A25-105709

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. Sitting											✓
b. Walking				✓							
c. Lifting			✓								
d. Bending			✓								
e. Squatting			✓								
f. Climbing			✓								
g. Kneeling			✓								
h. Twisting			✓								
i. Standing					✓						

4. Check the lifting restriction.
☑ 0–10 lbs. ☐ 10–20 lbs. ☐ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☑ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☐ Yes ☐ No

5c. Pushing and pulling? ☐ Yes ☐ No

5d. Fine manipulation? ☐ Yes ☐ No

6. Can the worker reach or work above the shoulder? ☐ Yes ☑ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☑ Yes ☐ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☑ Yes ☐ No to and from work only!

9. Are there cardiac, visual, or hearing limitations?
☑ No ☐ Yes – *(Describe)*

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases? ☐ No ☑ Yes – *(Describe)*
cannot work outside

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☑ No ☐ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☑ Yes ☐ No – *(Indicate when)*

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☑ Yes ☐ No Counseling to assist in adjustment to work environment

14. Has the worker reached maximum improvement?
☐ Yes *(Indicate when)* 4/80 ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)*
As long as patient refuses surgery, physical limitations will not improve.

16. Name: Raymond Y. Alexander

17. Signature: Raymond Y. Alexander

18. Address: 1409 Charles Street
Baltimore, MD 21906

19. Telephone No.: 685-9012

20. Date: 3/8/84

Copy Distribution: WHITE – Carrier/Employer YELLOW – OWCP Case File PINK – OWCP Rehab. File

GPO 851 040

Form OWCP-5
Sept. 1978

TASK BOOK
REHABILITATION
CASE 2
TASK 2

JOB DESCRIPTION SUMMARY

SUPPLY CLERK

Requisitions and maintains supplies for a medium size postal facility. Required to load and unload supply crates weighing 50 pounds. Types supply requisitions. Performs inventory functions. Must be able to type 40 words per minute and use standard office equipment such as an adding and xerox machine.

JOB DESCRIPTION SUMMARY

WINDOW CLERK

Sells postal products to customers. Is required to stand eight hours per day at the counter in the post office lobby. Must accept packages to be mailed over the counter weighing up to 70 pounds. Lifting above shoulder level is required. When lobby is not busy, employee is required to manually file mail.

TASK BOOK
REHABILITATION
CASE 2
TASK 2

JOB DESCRIPTION SUMMARY

SAFETY INSPECTOR

Conducts on-site safety inspections of postal facilities. Well developed communication skills required. In inspecting physical facilities, incumbent is required to climb ladders and steps, required to bend and twist. Must provide own transportation to facility sites.

These three positions are the only three jobs available. Currently there are no completely sedentary jobs available.

Select the position that best meets Ms. Washington's physical capabilities and which requires the least amount of modification. Circle your answer below.

a. Supply clerk. Turn to page 328, Box 4.

b. Window clerk. Turn to page 300, Box 3.

c. Safety inspector. Turn to page 301, Box 4.

You have decided the position of supply clerk requires the least amount of modification and best meets Ms. Washington's physical capabilities.

Read the following job description for supply clerk on page 294. Then turn to page 295 and do the task.

TASK BOOK
REHABILITATION
CASE 2
TASK 3

JOB DESCRIPTION

Position Title: Supply Clerk
Position Number: KP-8
Level: PS-5
Occupational Code: 2315-04

Functional Purpose: Requisitions and maintains supplies for a postal facility.

Organizational Relationships: Reports to Supply Supervisor

Job Duties:

1. Type and xerox supply requisitions
2. Perform on-site inventory functions, moving boxes of inventory to assigned locations. Review detached units inventory reports comparing stated supplies and equipment with their authorization
3. Occasionally loads and unloads supply crates weighing 50 pounds.
4. Accepts emergency telephone supply orders and types the requisition.

Proficiency Requirements:

1. Ability to type 40 words per minute
2. Ability to use standard office equipment such as an adding and xerox machine.

Environmental Factors: Clerical duties will be performed using a standard office desk and executive chair. The chair will have arm and back rests and will swivel.

Physical Requirements: This position requires that the employee be able to stand up to four hours per day, five days per week and walk to and from the worksite. The position requires occasional lifting of crates weighing up to 50 lbs. On-site inventory functions require repetitive movements such as bending, reaching, twisting, or squatting.

TASK BOOK
REHABILITATION
CASE 2
TASK 3

The position of supply clerk now needs to be modified to meet Ms. Washington's physical limitations. For the section on Job Duties below, select the item which best describes the modifications required, then turn to the page indicated next to your selection.

"Job Duties

1. Type and xerox supply requisitions.
2. Perform on-site inventory functions, moving boxes of inventory to assigned locations. Review detached units inventory reports comparing stated supplies and equipment with their authorization.
3. Occasionally loads and unloads supply crates weighing 50 pounds.
4. Accepts emergency telephone supply orders and types the requisition."

a. Duty 1: Employee will xerox supply requisitions not to exceed two hours standing a day.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates.
Duty 4: O.k. as is.
Turn to page 333 Box 2.

b. Duties 1 and 4 are acceptable.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates.
Turn to page 330, Box 1.

c. Duties 1 and 4 are acceptable.
Duty 2: Eliminate "moving boxes of inventory".
Duty 3: Employee will not be required to load or unload supply crates weighing 10 lbs or more.
Turn to page 332, Box 2.

d. Duty 1: Acceptable
Duty 2: Qualify "moving boxes" by adding not to exceed 10 lbs.
Duty 3: Eliminate
Duty 4: Eliminate requirement to answer the telephone.
Turn to page 331, box 3.

The physical requirements of the job as stated below must also be modified.

> "Physical Requirements: This position requires that the employee be able to stand up to four hours per day, five days per week and walk to and from the worksite. The position requires occasional lifting of crates weighing two to 50 lbs. On-site inventory functions require repetitive movements such as bending, reaching, twisting, or squatting".

Select the re-statement of the physical requirements below that best fits her limitations. Then turn to the page indicated to check your answer.

a. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day.
. Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, operating any type of motor vehicle, or reaching above the shoulders.
Turn to Page 331, Box 2.

b. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day and walk not to exceed 1 hour per day.
. Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, or reaching above the shoulders.
Turn to Page 333, Box 1.

c. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day.
. Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling.
Turn to Page 330, Box 2.

d. . Employee must be able to sit eight hours per day and stand not to exceed two hours per day and walk not to exceed 1 hour per day.
. Employee will not do any lifting, nor repetitive movements such as bending, squatting, climbing, kneeling, twisting, pushing, pulling, operating any type of motor vehicle, or reaching above the shoulders.
Turn to Page 332, Box 3.

TASK BOOK
REHABILITATION
CASE 2
TASK 5

When Ms. Washington was injured she was a Grade 5, Step 1. In 3/81 she began filing claims with OWCP because she was in an LWOP status as a result of her limited duty assignment being terminated. She was eligible for a recurrent rate because it had been more than six months since her first return to duty. Consequently, when she returned to limited duty her rate was a Grade 5 Step 2. While in a leave-without-pay status on OWCP rolls, Ms. Washington did earn one additional step increase, making her a Grade 5 Step 3 at the time of her separation.

During your reemployment interview, Ms. Washington poses the following question. What answer would you give her? Select the best answer to the following questions below.

(If you want to refer to the Resource Book, consult pages 70 - 75.)

"Suppose I accept your job offer and then am unable to continue working as a result of my accepted low back condition. What are my options?"

a. Your doctor has certified that the available job is within your work limitations and that you are capable of performing these duties. Turn to Page 331, Box 1.

b. If you find yourself unable to continue working because of your work injury you should probably apply for disability retirement. Turn to Page 333, Box 4.

c. If you are unable to continue working because of your back injury, you can obtain a new work restriction evaluation from the treating physician. Turn to Page 330, Box 3.

d. If you are unable to continue working because of your back injury, you should request a LWEC rating from OWCP. Turn to Page 332, Box 1.

Ms. Washington has a second question:

"When I was terminated from the Postal Service in March 1982, I was a Grade 5 Step 3, yet I am returning as a Grade 5 Step 2. Why?"

Which of the responses below is correct?

a. The salary is determined for former employees by the grade and step in effect at the time of injury or recurrent disability. Ms. Washington will be paid at her current rate for a Grade 5 Step 2 since this was the rate in effect on 3/81 at the time of recurrence. Turn to Page 330, Box 4.

b. The salary is determined for former employees by the grade at which the current job is classified. If that is less than the employee's former salary, the difference will be made up by compensation payments (LWEC). Turn to Page 333, Box 3.

c. The salary is determined for former employees by the grade and step the employee would be in if they had not received compensation. So, if Ms. Washington would have earned two step increases, she will return to a Grade 5 Step 4. Turn to Page 331, Box 4.

TASK BOOK
REHABILITATION
CASE 2
TASK 7

Ms. Washington has a final question: "What happens if I decline your job offer? Select the best answer below.

a. You will no longer be entitled to workers compensation. However you would still qualify for disability retirement from OPM. Turn to page 334, Box 1.

b. You will be asked to sign the declination of employment and state your reasons. The Employing Agency will notify OWCP of the job offer and the declination. If OWCP considers the position to be within the employee's physical capabilities, then compensation benefits will be terminated or reduced. Turn to Page 332, Box 4.

c. If you feel that the job being offered you is less desirable than your previous job, you may decline. However, you must agree to enter a vocational rehabilitation program to qualify for a job equivalent to your former one. Turn to page 334, Box 3.

From page 254

1

No. Even though you do want the opinion of a third doctor to resolve the dispute, the employing agency cannot require the claimant to undergo another exam.

Return to page 254 for a different answer.

From page 272

2

This is not the best answer because there has been a recent change in the status of disability.

Return to page 272 for another choice.

From page 292

3

Ms. Washington could possibly be accommodated in the window clerk position if she were allowed to sit rather than stand at the window. The lifting requirement would need to be waived and manual distribution of mail above shoulder level is outside her limitations. Further research would have to be done to determine if there is eight hours work available in the unit without lifting or filing mail above shoulder level.

There is a better choice. Return to page 292 and select again.

From page 274

4

Correct. Your light duty job must accommodate any conditions pre-existing the injury and those conditions resulting from the injury. Personal health conditions that arose later are not accommodated.

Turn to page 275 for the following task.

From page 274

1

This is partially correct. However, you need not accommodate any work restrictions that are "personal" or "concurrent".

Return to page 274 and choose a better answer.

From page 272

2

This is perhaps the case, but you have more certain grounds on which to question continued compensation.

Return to page 272 for a different choice.

From page 254

3

No. Even though one doctor offers only subjective findings and the other doctor presents objective findings, they are in conflict over whether or not the claimant is totally disabled. The conflict must be resolved first.

Return to page 254 for another choice.

From page 292

4

The position of safety specialist does not meet Ms. Washington's physical capabilities in that the assignment requires bending, climbing, twisting and all other physical activities required of an inspector. Also, the employee must provide transportation to the facility sites. It would not be cost effective for the employing agency to drive Ms. Washington to the job sites.

Return to page 292 and select again.

TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 1

Refer back to the Resource Book, pages 58 - 63, then do the following case.

Mr. Johnson injured his low back on 11/1/82 when he lifted a package weighing approximately 25 pounds from the floor to a handtruck. Mr. Johnson was treated by his family doctor, Jack Samuels, M.D., who considered him fit for limited duty and referred him to an orthopedic specialist. Orthopedist William X. Roseborough has seen Mr. Johnson on a monthly basis since 11/10/82 and continues to find him fit for limited duty. The last three CA-17's including the latest from Dr. Roseborough, dated 5/10/83 have been identical with only the examination date changing.

Review the following CA-1 and attending physician's reports from Doctors Samuels and Roseborough which follow on pages 303 - 310. Then turn to page 311 to do the task.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Johnson, George E	2-11-61		016-58-3422

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone
709 Bethlehem Rd Parkton, Md 21120	Area Code: 301 Number: 207-1843

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
U S Postal Service 1900 E Fayette Street Baltimore, Md 21233-9408	Fayette Street Station workfloor

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
11/1/82 7:15 ☒ AM ☐ PM	11/2/82	Wife/Husband ☐ Children Under 18 Years Old ☐	Letter Carrier

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Lifting a package weighing approximately 25 pounds from the floor to a handtruck.	Pain in my low back

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

George E Johnson
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

I saw carrier Johnson lift the package, drop it on to the handtruck and then grab his back. He appeared to be in pain

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Mary E Carter	908 Washington Pl. Bath Md 21229	11/2/82

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
U.S. Postal Service

22. Bureau or Office
Fayette Street Station

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
1900 E. Fayette Street
Baltimore, Maryland 21233

24. Regular Work Day
Begins 6:00 ☑ AM ☐ PM Ends 2:30 ☐ AM ☑ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) W (T) (F) (S)

27. Date and Hour of Injury *(mo., day, year)*
11/1/82 7:15 ☑ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
11/1/82 (Verbal)

29. Date and Hour Stopped Work *(mo., day, year)*
DID NOT STOP

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
N/A

31. 45 Day Period Begins *(mo., day, year)*
N/A

32. Pay Rate When Employee Stopped Work
$ 24,040 per yr.

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM
DID NOT STOP

34. Name of Supervisor at Time of Injury
Ralph Jones

35. Was Employee in Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*
11/1/82

39. Name and Address of Physician First Providing Medical Care
Jack Samuels, M.D
1411 Somner Road
Kingsville, Md 21128

40. Do Medical Reports Show Employee is Disabled For Work?
☐ Yes ☑ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☐ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor
Ralph Jones

46. Title and Office Phone Number
Supvr. Delivery 922-1315

47. Date *(mo., day, year)*
11/3/82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Jack Samuels, M.D
1411 Sumner Rd
Kingsville, Md. 21128

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Johnson, George E.	11/1/82	Letter Carrier

5. DESCRIPTION OF INJURY OR DISEASE

low back pain as a result of lifting a 25 pound package from the floor to a handtruck

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Ralph Jones	Supervisor, Delivery
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
922-1315	11/1/82

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency U.S. Postal Service Bureau or Office Fayette Street Station Local Address (Including Zip Code) 1900 E. Fayette St Balto Md. 21233

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
George E. Johnson

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
lifting 25 pound package feel a pain in my low back

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☐ Yes ☑ No

17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)?
tenderness right low back area

18. WHAT IS YOUR DIAGNOSIS?
acute lumbo-sacral strain

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☑ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☑ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ Yes ☐ No

22. SURGERY (If any, describe type)

23. DATE SURGERY PERFORMED (mo., day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
initial evaluation and referral to an orthopedic specialist

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

26. DATE OF FIRST EXAMINATION (mo., day, year)
11/1/82

27. DATE(S) OF TREATMENT (mo., day, year)
11/1/82 only

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)
referred 11/1/82

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM TO
PARTIAL DISABILITY: FROM 11/1/82 TO unknown

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK
REGULAR WORK

31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO IF YES, FURNISH DATE ADVISED (month, day, year) 11/1/82

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.
sedentary work only No lifting until evaluation by orthopedist

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.
Orthopedic referral

34. DO YOU SPECIALIZE? ☑ Yes ☐ No (If yes, state specialty) Family Practice

35. SIGNATURE OF PHYSICIAN
Jack Damiano, M.D

36. ADDRESS (Number, street, city, state, zip code)
1411 Somner Road
Kingsville, Md. 21128

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
107-15-1111

38. DATE OF REPORT (mo., day, year)
11/2/82

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price: Cost	Unit price: Per	Amount: $	Amount: ¢
	TOTAL					

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OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
William X Rosebrough, M.D.
811 Park Heights Avenue
Baltimore, MD 21209

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Johnson, George E	11/1/82	Letter Carrier	016-58-3422

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
low back pain as a result of lifting a 25 pound package from the floor to a vanatruck

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD 5 hours NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK — Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			3 hours
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS	0		
PULLING/PUSHING, CARRYING			5
REACHING OR WORKING ABOVE SHOULDER			3
WALKING (HOURS)			5
STANDING (HOURS)			3
SITTING (HOURS)	0		
STOOPING (HOURS)	0		
KNEELING (HOURS)	0		
REPEATED BENDING (HOURS)	0		
CLIMBING (HOURS)	1		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	1		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
U.S. Postal Service
Fayette Street Station
1900 East Fayette St
Baltimore, Md. 21233

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1984

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☑ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 11/10 TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☑ 11/10/82
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*
11/10/82

16. DIAGNOSIS OF CONDITION DUE TO INJURY
low back strain - no lifting over 10 pounds - refer to physical therapy

17. DATE OF EXAMINATION 11/10/82

18. DATES OF FURTHER APPOINTMENTS, IF ANY 12/10/82

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Wm X Roseborough, M.D

20. PROFESSIONAL DEGREE
Orthopedist

21. DATE *(Mo., day, year)*
11/10/82

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OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
William X. Roseborough, M.D
811 Park Heights Avenue
Baltimore, MD 21209

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Johnson, George E.	11/1/82	Letter Carrier	016-58-3422

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
low back pain as a result of lifting a 25 pound package from the floor to a handtruck.

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT _____ COLD 3 hours NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			3
LIGHT – LIFTING 10 to 20 POUNDS			3 hours
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS	D		
PULLING/PUSHING, CARRYING			Little
REACHING OR WORKING ABOVE SHOULDER			Little
WALKING (HOURS)			Little
STANDING (HOURS)			
SITTING (HOURS)	8		
STOOPING (HOURS)	8		
KNEELING (HOURS)	8		
REPEATED BENDING (HOURS)	0		
CLIMBING (HOURS)	1		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	1		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
U.S Postal Service
Fayette Street Station
1900 E. Fayette Street
Balto, Md 21233

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☑ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM 11/10/ TO continuing

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☑ 11/10/82
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)* 11/10/82

16. DIAGNOSIS OF CONDITION DUE TO INJURY
resolving low back strain - continue limited duty for another month - no lifting over 20 pounds - Prognosis guarded

17. DATE OF EXAMINATION 5/10/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY 6/10/83

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Wm X. Roseborough M.D

20. PROFESSIONAL DEGREE
Orthopedist

21. DATE *(Mo., day, year)* 5/10/83

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 1

Assume today's date is May 20, 1983. Mr. Johnson is still on the agency's rolls. Every six months, it is your policy to review all temporary limited duty assignments. Select the choice below which best describes the action you would take at the conclusion of your review:

a. Continue the assignment until your next review. Turn to page 327, Box 2.

b. Require additional medical evidence from the treating physician to support the continuing need for limited duty. Turn to page 326, Box 4.

c. Request OWCP to do an LWEC. Turn to page 329, Box 2.

d. Get another medical opinion through a fitness for duty. Turn to page 328, Box 3.

If you wish to consult the Resource, refer to pages 59 - 63.

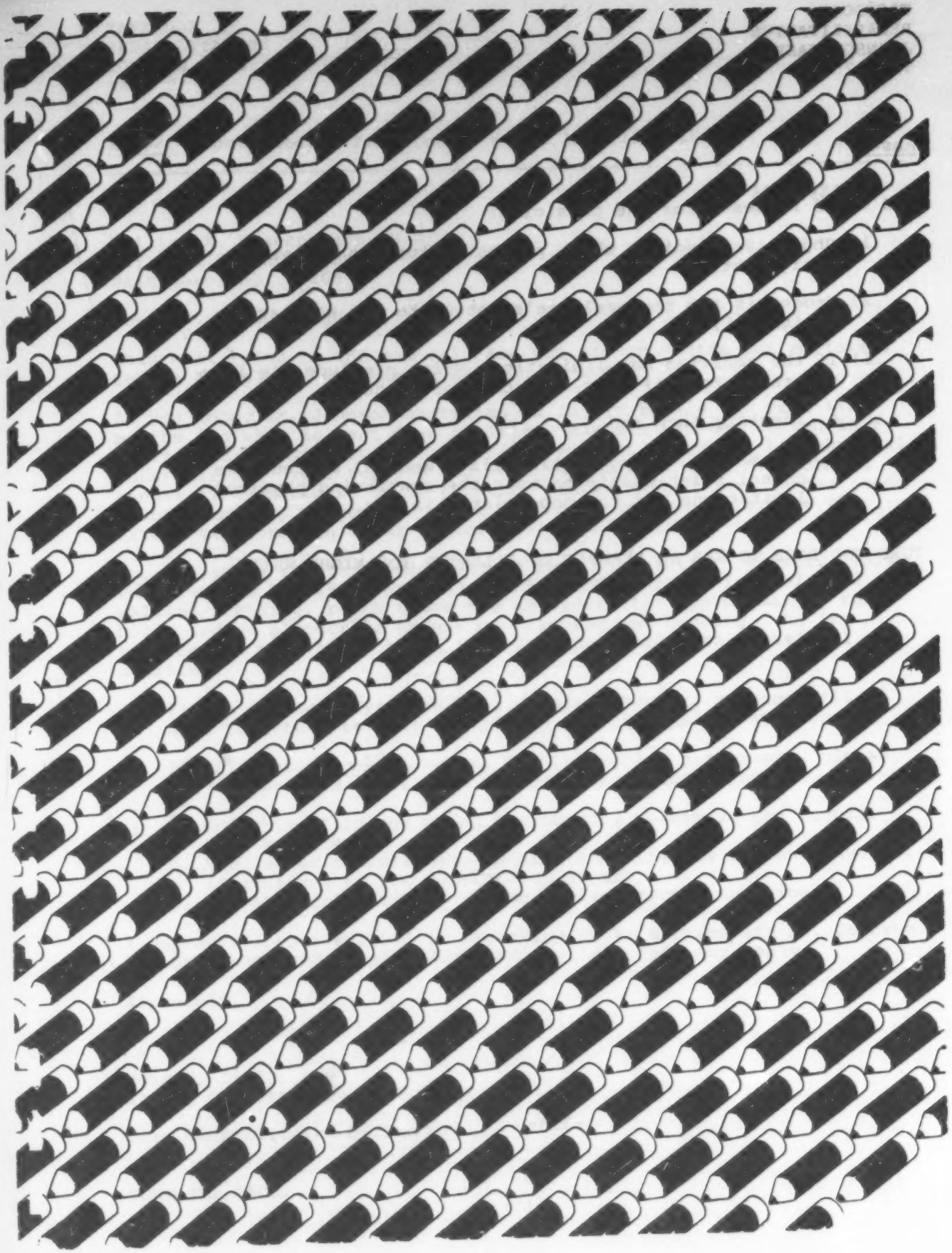
TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 2

Your limited duty review reveals that additional medical evidence is needed from the treating physician. You will have to prepare a letter requesting the required information to make a determination on Mr. Johnson's need for continuing limited duty. For this task, list below the information you would request from the physician.

If you want to refer to the Resource, the material covering this area can be found on pages 65 - 66 in the Resource.

WHEN YOU HAVE FINISHED, TURN TO PAGE 313 TO COMPARE YOUR ANSWER WITH THE BOOK ANSWER.

END OF TASK MATERIAL



Answer:

You would request from the physician:

1) Objective findings which prevent return to the work assignment,

2) Prognosis for the employee's return to his regular assignment,

3) If the employee has limitations which preclude him from returning to full duty, the physician should:

   a. Identify them and

   b. Establish, through rationalized medical evidence, a causal relationship between the continuing physical limitations and the job-related injury.

TURN THE PAGE TO SEE AN EXAMPLE OF A LETTER YOU MIGHT WRITE.

Answer (continued): Your letter might look like this:

May 20, 1983

William X. Roseborough, M.D.
811 Park Heights Avenue
Baltimore, MD 21209

Dear Dr. Roseborough:

This will refer to the medical care you are providing our employee, George E. Johnson who was injured on 11-1-82.

As you know, Mr. Johnson sustained an injury to his low back six months ago when he bent down to lift a parcel. He has worked in a limited duty assignment since 11/1/82 with no change in his physical restrictions. Your reports continue to indicate that Mr. Johnson cannot lift in excess of 20 pounds. Since limited duty is designed to be temporary in nature, it is essential that we determine the extent and duration of Mr. Johnson's physical limitations.

Mr. Johnson's regular assignment is that of a letter carrier. This requires him to lift a maximum of 35 pounds, engage in prolonged walking/standing, reach above the shoulders for approximately three hours and do a moderate amount of climbing and bending. He is required to work eight hours five days per week with occasional overtime.

1. Please advise in your medical opinion when Mr. Johnson will be able to return to this assignment and the approximate date.

2. If Mr. Johnson cannot return to his regular assignment, please provide us with a detailed medical report including:

   a. Objective findings which prevent his return to the regular work assignment.
   b. A reasoned medical opinion that connects his current physical limitations to the job-related injury.
   c. His physical limitations and their expected duration.

I appreciate your efforts in assisting us to accommodate Mr. Johnson and have enclosed a self-addressed envelope for your reply.

Sincerely,

John S. Lilly
Injury Compensation Supervisor

cc: OWCP District Office

TURN THE PAGE.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 3

Review Dr. Roseborough's response to your request for medical information on the following page. Then turn to page 317 and answer the questions.

William X. Roseborough, M.D.
Orthopedic Specialist
811 Park Heights Avenue
Baltimore, MD 21209
June 10, 1983

Mr. John S. Lilly
Injury Compensation Supervisor
U. S. Postal Service
1900 E. Fayette Street
Baltimore, MD 21233-9408

Dear Mr. Lilly:

Thank you for your recent letter concerning your employee and my patient, George A. Johnson.

It is unfortunate that I cannot provide you with the straightforward information you require. Both myself and Mr. Johnson had expected a return to his letter carrier position by now. His low back strain has not responded to conservative treatment, yet objective findings do not warrant more aggressive medical care.

In view of the above, it is recommended that Mr. Johnson continue in his limited duty assignment for another three months. His physical limitations are no lifting over 20 pounds and my diagnosis remains resolving low back strain. I will reevaluate Mr. Johnson in three months for a possible return to full duty.

William X. Roseborough, M.D.
Orthopedic Specialist

TURN THE PAGE.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 3

Write your answers to the following questions below.

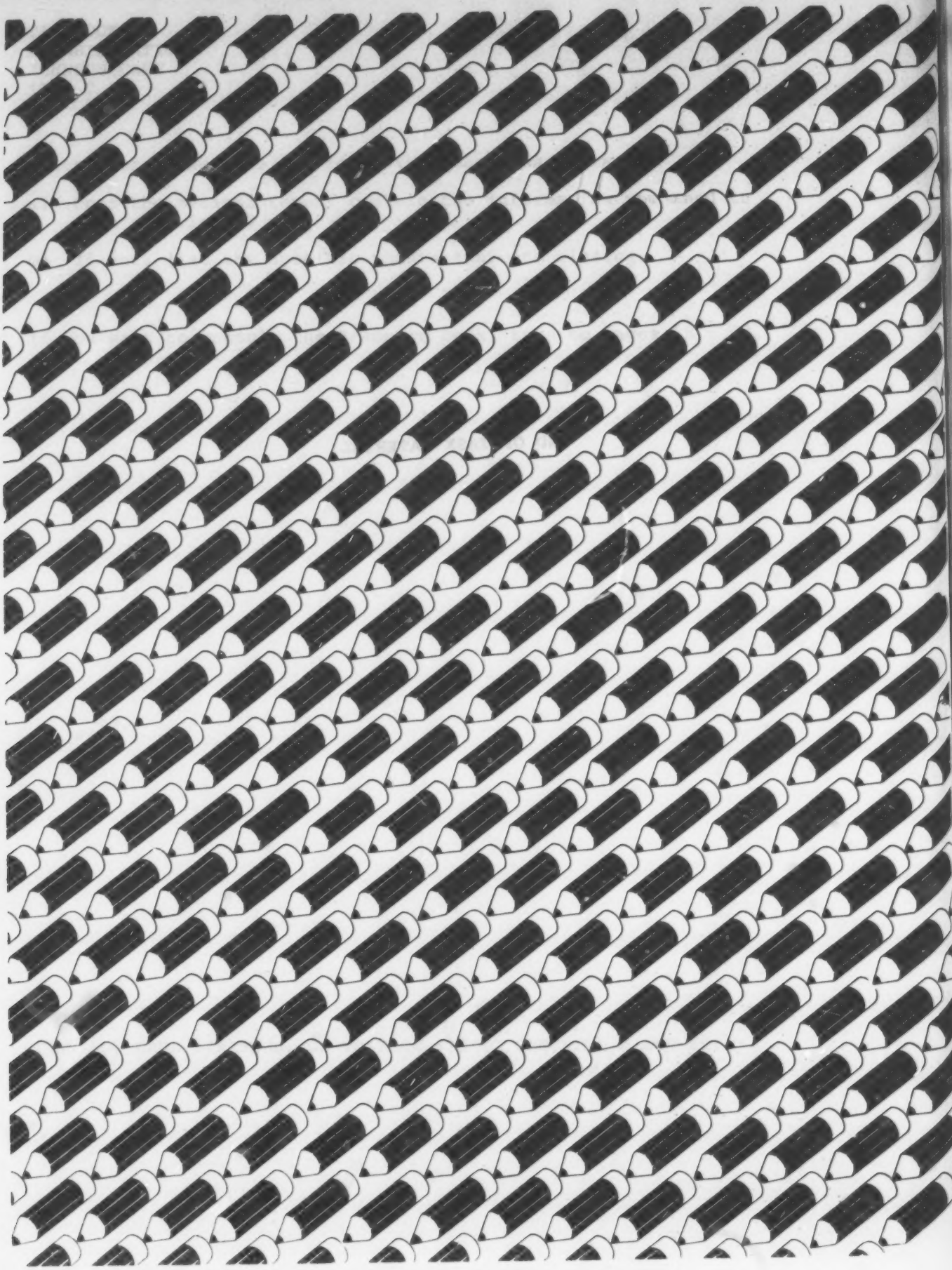
a) Does the medical report contain the information you need to make a decision?

b) If not, list the specific points that are missing.

If you want to consult the Resource Book, turn to pages 59 - 63.

WHEN YOU HAVE FINISHED, GO TO PAGE 318 TO CHECK YOUR ANSWER.

END OF TASK MATERIAL



Answer:

a) The medical report does not contain the information needed to make a decision.

b) The following are missing from the report:

1) Detailed objective findings.

2) Reasoned medical opinion establishing a relationship between the physical restrictions and the job-related injury.

GO ON TO THE NEXT TASK.

Select the best course of action from the choices below. Then turn to the page indicated next to your selection to check your answer.

a. Continue Mr. Johnson in the limited duty assignment pending the next medical reevaluation. Turn to page 328, Box 2.

b. Request that OWCP get a second opinion on Mr. Johnson. Turn to page 327, Box 1.

c. Require Mr. Johnson to take a Fitness for Duty medical exam. Turn to page 329, Box 3.

If you want to review the Resource, refer back to pages 59 - 63.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

Your Installation Head has approved the scheduling of a Fitness for Duty examination on George E. Johnson. You have selected Board Certified Orthopedic Specialist Joseph R. Holmes to conduct the examination. You have provided Dr. Holmes with job descriptions for Mr. Johnson's regular and limited duty assignments, a copy of the original injury report, as well as all medical reports pertaining to the injury. You have requested that Dr. Holmes do a one time medical evaluation of Mr. Johnson's low back condition and that he specifically address the issues of fitness for duty, objective physical findings and their relationship to the injury, and the extent and duration of any physical restrictions stemming from this injury.

Dr. Holmes conducted his examination and provided you with his report on pages 321 and 322. Review his findings and decide your next course of action.

Then go to page 323 to choose your answer.

TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 5

July 30, 1983

Mr. John S. Lilly
Injury Compensation Supervisor
U. S. Postal Service
1900 E. Fayette St.
Baltimore, MD 21233-9408

Dear Mr. Lilly:

After reviewing all the information provided me, a Fitness for Duty examination was performed on George E. Johnson on 7/19/83 in regard to his low back condition.

General health was good and general physical examination was within normal limits.

Mr. Johnson is a 22 year old white male with no history of orthopedic problems until he injured his low back on 11/1/82 lifting a 25 pound package. He was treated by his family doctor Jack Samuels, M.D. who referred him to orthopedist William X. Roseborough, M.D. Mr. Johnson does not remember if Dr. Roseborough took X-rays of his back but he does remember going to physical therapy. Mr. Johnson has worked limited duty since his injury.

Subjective complaints from Mr. Johnson include pain on rising, pain when he bends to lift, and general "achiness" at the end of the work day. Mr. Johnson also stated that he is becoming very depressed about his physical condition and is considering changing doctors to a chiropractor.

Examination:

In the supine position (on his back) the employee had no complaints of pain. Straight leg raising, both right and left legs separately and both legs together caused no low back pain and he was able to elevate his legs to the full extent. The deep tendon reflexes at the knees and ankles were normal, both without and with reinforcement. Range of motion of the entire back was performed normally and to the full extent without any

complaints of pain. He was able to move his back easily in all directions. Heel/toe stand/walk was normal without complaints. Deep squatting was performed normally without complaints. There was no tenderness of the backbones or back muscles to palpation or to percussion. There was no sensory loss. Babinski reflex was normal bilaterally (stimulating the soles of the foot). Muscle strength and tone of the back muscles and leg muscles were normal. There were no muscle spasms of the back.

The only abnormal finding was mildly poor posture; kyphosis (round shouldered) and lordosis (sway back). X-rays normal lumbar spine.

Impression:

Normal musculoskeletal and neurologic exam, with the exception of mildly poor posture, round shouldered and sway backed.

Duty status:

After reviewing the job description for Letter Carrier, it is my opinion that Mr. Johnson could perform all the physical requirements of the position including the requirement to lift 35 pounds. He has no physical restrictions as a result of his 11/1/82 low back injury.

Joseph A. Holmes, M. D.
Orthopedic Specialist

Which course of action should you now take? Select one decision below.

a. There is a conflict of medical opinion. Request OWCP to order an impartial medical exam to resolve the conflict. The claimant stays on light duty until the conflict is resolved. Turn to page 326, Box 2.

b. There is a conflict of medical opinion. Resolve it by scheduling the claimant to see a third doctor to resolve the conflict. The claimant must stay on light duty meanwhile. Turn to page 328, Box 1.

c. The objective findings of Dr. Holmes take precedence over the subjective opinion of the treating physician. Mr. Johnson may now be returned to regular duty. Turn to page 327, Box 4.

d. There is an unresolved difference of medical opinion. Ask OWCP for an impartial exam. Due to Dr. Holmes' clearance for regular duty, you may reassign the claimant to regular duty. Turn to page 329, Box 1.

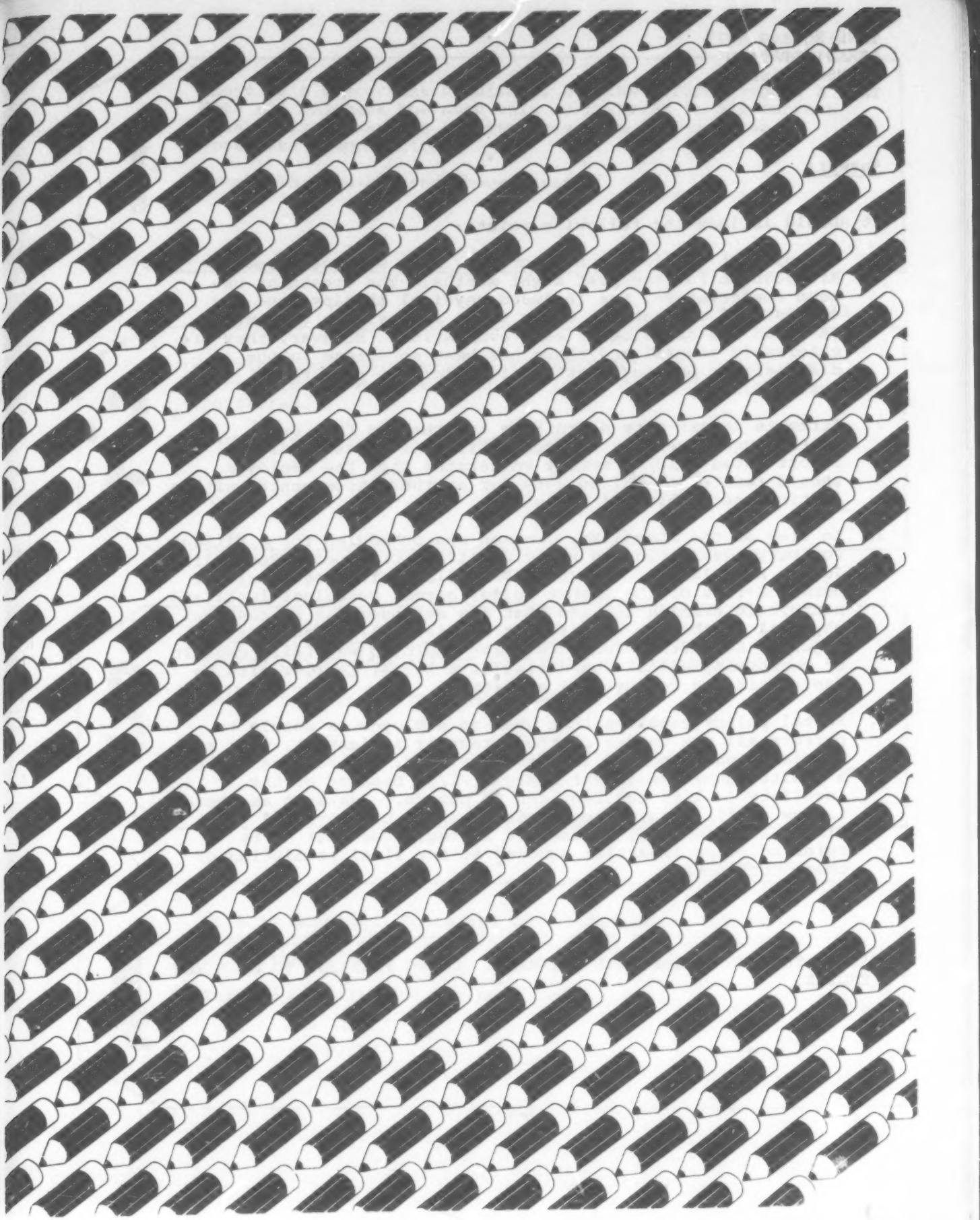
TASKBOOK
REHABILITATION
JOHNSON CASE
TASK 6

In a letter to OWCP forwarding Dr. Holmes' evaluation, list the points you will make that support your requesting a final determination on the employee's physical limitations and duty status.

If you wish to review resource material, consult pages 59 - 63 of the Resource Book.

TURN TO PAGE 325 TO CHECK YOUR ANSWER.

END OF TASK MATERIAL



TASK BOOK
REHABILITATION
JOHNSON CASE
TASK 6

Answer:

It should include the following points:

1. Orthopedist William X. Roseborough, M.D. has been treating Mr. Johnson for the past eight months. The treatment has been conservative, has included physical therapy, and now consists of evaluations every three months. We receive a CA-17 on the occasion of each evaluation. However, they are exteremely general and there has been no change in the diagnosis or physical restrictions for the past three evaluations.

2. Attempts to get more definitive information from Dr. Roseborough have been unsuccessful. His latest medical report dated 6/10/83 merely reiterates that the employee should remain on limited duty for another three months with a lifting restriction of 20 pounds.

3. In view of the above, Mr. Johnson was scheduled for a Fitness for Duty examination by Board Certified Orthopedic Specialist Joseph R. Holmes on 7/19/83. Dr. Holmes' findings included normal X-rays of the lumbar spine, normal musculoskeletal and neurologic examination and that the employee has no residual physical disability as a result of his 11/1/82 job-related injury. He further found that the employee was fully capable of performing all of the duties of a Letter Carrier with no restriction as to physical ability.

4. Postal policy requires that when an employee is unable to perform all the duties of their regular assignment, they must be placed on temporary limited duty. Mr. Johnson has worked a limited duty assignment since 11/1/82 because of his inability to lift the required 35 pounds. Inasmuch as there is now conflicting medical opinion as to his physical limitations and their cause, it is requested that he be referred to an impartial specialist for final resolution of these conflicts.

THIS IS THE END OF THE CASE MATERIAL. GO TO PAGE 335 TO DO A NEW EXERCISE.

From page 272

1

There is a concurrent condition, but the medical report does not indicate how much this contributes to his current disability. There is a better basis to question the continued compensation.

Return to page 272 and choose again.

From page 323

2

Correct. OWCP must resolve the conflict. Meanwhile you cannot ignore work restrictions imposed by the treating physician.

Turn to page 324 for the next task.

From page 274

3

This is a direct course of action, but you cannot require an FFD for someone who is no longer on the agency rolls.

Return to page 274 and try again.

From page 311

4

This is correct. There are no reasons given for why a back sprain would incapacitate a young man this long (6 months).

Turn to page 312 for the next task.

From page 319

1

This is a possible course of action. However, there is a more direct way to handle the problem.

Return to page 319 for another choice.

From page 311

2

There does not seem to be any point in delaying action at this point. A back sprain will normally resolve itslelf in 6-8 weeks. It has been 6 months, and there has been little change.

Return to page 311 and make a different selection.

From page 274

3

This is partially correct. However, you may have to accommodate other work limitations in this case.

Return to page 274 and choose again.

From page 323

4

No. Until the conflict is resolved, you cannot violate work restrictions imposed by the treating physician.

Return to page 323 for another choice.

From page 323

1

No. You do not have authority to resolve a conflict in medical opinion.

Return to page 323 for another choice.

From page 319

2

This would put off the decision for another 3 months. Since it is already 6 months since the injury, it is time to take a more active role.

Return to page 319 for another choice.

From page 311

3

It might eventually be necessary to do this in order to get the information you need. However, there is something simpler you can do.

Return to page 311 and choose again.

From page 292

4

Correct. The position of supply clerk would appear to best meet Ms. Washington's physical restrictions and require the least amount of modification. The only modificationn necessary would be lifting 50 pound crates.

Now turn to page 293 for the next task.

best copy available

From page 323

1

This is mostly correct. However, you cannot violate work restrictions imposed by the treating physician until the conflict in medical opinion is resolved.

Return to page 323 for another choice.

From page 311

2

There is no need for this. The claimant is working on light duty and there are no clear reasons why he shouldn't soon return to regular duty.

Return to page 311 and choose again.

From page 319

3

Yes, this is the best choice. An injury that usually resolves itself in 6-8 weeks requires serious investigation if it is still not better after 6 months. Since Mr. Johnson is still an employee of the agency, you can resolve the situation faster with a Fitness for Duty exam. You don't need to go to OWCP.

Turn to page 320 for the following task.

From page 272

4

Correct. The treating physician states that Perry is now able to work on a limited basis.

Turn to page 274 for the next task.

From page 295

1

Mostly correct. The modifications for duties 2 and 3 are correct.

Reexamine duties 1 and 4 to see if some imposed limitation could be violated.

Return to page 295 for another choice.

From page 296

2

Partly correct, but there are some further work limitations that are not included in this description.

Review the work restriction evaluation on page 288, then return to page 296 for another choice.

From page 297

3

Correct. The treating physician can reevaulate the claimant's condition which may have changed since the previous time.

Turn to page 298 and do the next task.

From page 298

4

Correct. Since Ms. Washington is a Postal Service employee this special rule applies.

Now turn to page 299 for the next task.

From page 297

1

True. However, this does not deal with the "what if" question. The claimant's condition could get worse. What then?

Return to page 297 and make another selection.

From page 296

2

Mostly correct, but there is still some further change required.

Reexamine the work restrictions on page 288. Then return to page 296 for another choice.

From page 295

3

Partly correct. The answer choices for duties 1 and 3 are not the problem. Reexamine your revisions of duties 2 and 4.

Return to page 295 for another choice.

From page 298

4

In most agencies this is correct. However, Ms. Washington is a Postal Service employee and is subject to special rules.

Check the Resource book page 73, then return to page 298 and select another choice.

From page 297

1

This is possible but may not be necessary.

Return to page 297 for another choice.

From page 295

2

Mostly correct, but there is still a work limitation that would be violated.

Return to page 295 for another choice.

From page 296

3

Correct. All work limitations have been accommodated.

Turn to page 297 for the next task.

From page 299

4

Correct. OWCP will make the determination after receiving the documents from the agency.

Go on to page 302 for the next case.

From page 296

1

Mostly correct. Reexamine the work restrictions on page 288. Then return to page 296 for a different selection.

From page 295

2

Correct. All changes are required by Ms. Washington's work limitations.

Turn to page 296 and do the next task.

From page 298

3

No. Once the employee returns to work, compensation ceases and all income is from employment.

Return to page 298 for another choice.

From page 297

4

This is possible but may not be necessary and is not her best option.

Return to page 292 and selecet a better answer.

From page 299

1

The case may result in a termination of compensation.

But in order to qualify for disability retirement the claimant would have to demonstrate total disability and this is not the case.

Return to page 299 for another choice.

2

From page 299

3

There is no such provision. Rehabilitation results in the claimant getting the same pay, but there is no guarantee of an equivalent job.

Return to page 299 for another choice.

4

COMPENSATION PROGRAM SELF AUDIT

To be effective the compensation specialist must develop the technical skills to thoroughly review initial claims, prepare controversion when warranted, and review long-term cases for re-employment or other disposition.

However, to have a successful compensation program in your installation, you must also develop and maintain effective working relations with three specific groups. These are:

1. The managers and supervisors at the installation.

2. The medical practitioners utilized by claimants.

3. The OWCP District Office that services your claims.

For each group there are specific educational and collaborative activities that are important to initiate.

In order to evaluate the strength and weaknesses of the compensation program at your facility, complete the following tasks:

1. Read pages 77 - 87 in the Resource Book on these three relationships

2. Complete the "Compensation Program Self Audit" and score it.

3. When you have completed and scored the self audit, read the Instructions on page 341, then complete the "Action Planning Sheet" on page 342.

COMPENSATION PROGRAM SELF AUDIT

SECTION I

RELATIONS WITH MANAGEMENT

For each of the following items indicate the extent to which these practices are followed in your installation. Place the appropriate number in the blank provided.

All the time..... = 4

Most of the time ..... = 3

Fairly often ..... = 2

Rarely ..... = 1

Never ..... = 0

1. Supervisors report or have the employee report all compensatory injuries to the compensation office within 24 hours of their occurrence. ____

2. Supervisors see that injured employees immediatly complete a CA-1, and themselves correctly complete and submit the CA-1 within 48 hours. ____

3. The level of information reported by the supervisor on the CA-1 and/or an attached statement is adequate. ____

4. Supervisors recognize the claims that can legitimately be controverted. ____

5. Supervisors correctly follow the rules for time-keeping under COP. ____

6. Supervisory training on claims reporting and handling is provided for supervisors. ____

(CONTINUED ON NEXT PAGE)

7. Supervisors are aware of the technical assistance available from the compensation office and utilize this assistance when needed. ____

8. Information on FECA benefits, basis of entitlement and agency compensation program are disseminated to all managers through administrative instructions, memoranda or other official means. ____

9. Executive and management meetings include a report and discussion of the installation's compensation program at least quarterly. ____

10. The compensation office reports to top management at least quarterly on the compensation costs for the installation. ____

11. The installation management supports a light duty program for temporary partially disabled claimants. ____

12. Organizational units are able to provide sufficient light duty assignements for partially disabled claimants. ____

13. Employees on light duty are periodically (every 2-3 weeks) re-evaluated for changes in their work restrictions. ____

14. Light duty assignments automatically terminate at least within 12 months and a decision is made for permanent disposition of the case. ____

15. Management offers modified jobs to permanently and partially disabled claimants. ____

SUBTOTAL ____

SECTION II

RELATIONS WITH DOCTORS

For each of the following items, use the same scoring system you used for Section I, with 4 indicating "all the time" and 0 indicating "never".

16. At least quarterly compensation office staff hold meetings or make other special efforts to educate medical practices in the community for the purpose of improving the usefulness of medical reports. ____

17. Compensation office staff make sure that local physicians who treat our injured employees are aware of our light duty program. ____

18. The compensation office (or the agency medical office) speaks directly with the treating physician to clarify any work limitations questions in a case. ____

19. Medical practices are instructed to send bills to the agency compensation office. ____

20. Medical practices are instructed by the compensation office on what things OWCP needs in order to process bills. ____

21. Doctors are encouraged to call the compensation office to discuss any questions they may have concerning the accommodation of work limitations for an employee. ____

22. The compensation office uses a list of competent and cooperative medical practices and specialists to assist the employee in selecting an appropriate one. ____

23. Initial medical reports are received from doctors within 4 or 5 days. ____

24. The compensation office contacts the treating physician for an initial status report within 24 hours of the initial treatment if the status cannot be learned from the employee. ____

SUBTOTAL ____

SECTION III

RELATIONS WITH OWCP

For the following questions, place a 3 in the blank if the statement is true and a 0 in the blank if it is not so.

25. Compensation office staff has visited the OWCP District Office to learn how OWCP processes claims and bills. ____

26. The chief compensation officer has personally met and discussed problems with OWCP's Deputy Commissioner. ____

27. Your facility has arranged to get a chargeback listing from OWCP at least on an annual basis. ____

28. The compensation office has clarified with OWCP the types of controversion cases that will be upheld. ____

29. The compensation office has arranged a system with OWCP to update files. ____

30. The Deputy Commissioner or his representative has toured your facility and become acquainted with the type of work done, the equipment used and common injuries. (This would not apply for an agency that has desk-type jobs only.) ____

31. The compensation staff has an arrangement to routinely discuss problem cases with claims examiners. ____

32. The compensation office has developed good enough working relations with the District Office that you are confident that any serious problem will receive due attention. ____

SUBTOTAL ____

SCORING SHEET

To get your overall score follow these steps:

1. Enter the Subtotal of Section I on the blank on this line _____

2. Enter the scores for the following items in the blanks provided:

   Item 6 _____

   Item 11 _____

   Total for Section I . . . . . _____

   Total possible score for Section I is 68.

3. Enter the Subtotal of Section II on the blank on this line _____

4. Add the following scores:

   Item 16 _____

   Item 21 _____

   Total for Section II . . . . . _____

   Total possible score for Section II is 44.

5. Enter the Subtotal of Section III on the blank on this line _____

6. Add the following scores:

   Item 26 _____

   Item 28 _____

   Item 31 _____

   Total for Section III . . . . . _____

   Total possible score for Section III is 44.

If you are significantly below the possible score for any section there may be serious weaknesses to your program. This is especially true if you scored less than 3 on any of the seven weighted items listed above.

ACTION PLANNING SHEET

INSTRUCTIONS

After reviewing what you consider the most serious weaknesses in your program, select at least one action step that would strengthen your organization's program in some important way.

In selecting an action to plan, use the following criteria:

a. Choose from 1 to 3 actions. Write them out in the space below.

b. Choose actions that are within your power to do (something you can do yourself).

c. Choose actions that you think have a high probability of success.

d. Choose actions of relatively short range (the results will be visible in 30 to 60 days).

Using the Action Planning Sheet on the following page (342), for one of your actions draw up a plan, with specific steps and a time table. There are two additional Action Planning Sheets on pages 343 and 344 if you want to draw up additional plans.

ACTION PLANNING SHEET

Proposed Action:

_____

_____

_____

_____

_____

Rationale:

_____

_____

_____

_____

_____

Plan:

	Action Steps:	Target Date:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

ACTION PLANNING SHEET

Proposed Action:

_____

_____

_____

_____

_____

Rationale:

_____

_____

_____

_____

_____

Plan:

	Action Steps:	Target Date:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

ACTION PLANNING SHEET

Proposed Action:

_____

_____

_____

_____

_____

Rationale:

_____

_____

_____

_____

_____

Plan:

	Action Steps:	Target Date:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

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